

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7292

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROHRSERSVILLE MD.</u>		c. LENGTH OF STAY IN 1b <u>54 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROHRSERSVILLE MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM - DAVID - ALBIN</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 25 - 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY - 6 - 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>4 19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PRINCIPLE OF PUBLIC SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MIDVALE PENN.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. ALBIN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH STEPHEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>219-20-4726</u>		17. INFORMANT <u>MRS. CHARLOTTE ALBIN ROHRSERSVILLE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1958</u> , to <u>June 25, 1959</u> , that I last saw the deceased alive on <u>June 25, 1959</u> , and that death occurred at <u>3:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>6/26/59</u> ACTUAL SIGNATURE <u>G. W. L. Lavan</u> M.D. <u>Boonsboro</u> PHYSICIAN'S NAME (Type) <u>G. W. L. Lavan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE - 27 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bass</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		MEDICAL HISTORY _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7235

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07224

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KEEDYSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>A</u> Middle <u>C. RACE</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-21-1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. CO. MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>BENJAMIN F. BAKER</u>				14. MOTHER'S MAIDEN NAME <u>EVA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ROBERT WYAND</u>		Address <u>KEEDYSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Megacolon</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Enterocolitis</u> DUE TO (c) <u>Parkinsons-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 years</u> <u>19 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>59</u> , to <u>June 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Helman</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro - Md.</u>		DATE SIGNED <u>6/8/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Helman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 10 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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7234

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07223

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years 9 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Hospital				d. STREET ADDRESS 38 East Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMANDA Middle E. Last BAKER				4. DATE OF DEATH Month June Day 14 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1869		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shippensburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Mc Clure				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Isadora Mc Clure Address East Greenwich, Conn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 450.0 DUE TO Arteriosclerosis - gen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gen. (c)						INTERVAL BETWEEN ONSET AND DEATH min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14/59 , 19____, to 6/14/59 , 19____, that I last saw the deceased alive on 6/14/59 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam DATE SIGNED 6/15/59 ACTUAL SIGNATURE Louis E. Shaw M.D. PHYSICIAN'S NAME (Type) Louis E. Shaw Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR JUN 18 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1950

DATE OF DEATH

PLACE

CITY AND

STATE

DEATH CERTIFICATE

DATE OF DEATH

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DEATH CERTIFICATE

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7236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07225

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 18 Elizabeth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORA First MAY Middle BAKER Last				4. DATE OF DEATH Month June Day 11 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen work			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mc Coys Ferry, Maryland		
13. FATHER'S NAME William Patton			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT Donald Baker Address Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of ulcerative lesions of caecum DUE TO (c) Carcinoma of caecum INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 days 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary embolism; arteriosclerotic heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that I attended the deceased from June 6 , 19 59 , to June 11 , 19 59 , that I last saw the deceased alive on June 11 , 19 59 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John D. Turco			ADDRESS (Street, city or town, state) 302 W. Phoenix St				
PHYSICIAN'S NAME (Type) JOHN D TURCO			DATE SIGNED Hagerstown, Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORY River View Cemetery			
22d. LOCATION (City, town, or county) Hancock		22e. (State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Sater - Rouzer Funeral Home			ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna							

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7293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Pa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McConnellsburg, Pa.</u>	
c. LENGTH OF STAY IN 1b. <u>5 weeks</u>		d. STREET ADDRESS <u>75X-31</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salway Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lydia</u> First <u>Bard</u> Middle <u>Bard</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1868</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>29</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton Co, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Baltzer W. Melloff</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hollinshead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>George Bard, McConnellsburg Pa.</u>	
17. INFORMANT <u>George Bard, McConnellsburg Pa.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Sclerosis</u> DUE TO (c) <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1959</u> to <u>June 16, 1959</u> , that I last saw the deceased alive on <u>June 15, 1959</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>6/19/59</u>	
PHYSICIAN'S NAME (Type) <u>David R Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Ayr Twp. Fulton, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Lininger</u> ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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Butterfly

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David R Byrnes

7237

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Barnhart Last Barnhart				4. DATE OF DEATH Month 6 Day 4 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26.1886		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 1 Days 10	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barnhart				14. MOTHER'S MAIDEN NAME Elizabeth Jordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Webster Barnhart Address Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, right middle cerebral artery DUE TO (c) Hypertension cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD							INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4 , 19 59 , to 6/4 , 19 59 , that I last saw the deceased alive on 6/4 , 19 59 , and that death occurred at 9:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 S. Prospect St. DATE SIGNED 6/5/59 ACTUAL SIGNATURE John C. Stauffer M.D. PHYSICIAN'S NAME (Type) John C. Stauffer, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.7.59		22c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Shaw				ADDRESS Hancock Md		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

1937

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

Name of Deceased William Henry		Date of Birth May 1, 1880	
Sex Male		Race White	
Usual Residence 123 Main Street, Boston, Mass.		Date of Death June 15, 1937	
Cause of Death Heart Disease		Place of Death Home	
Signature of Physician J. H. Smith, M.D.		Signature of Registrar A. B. Jones	
Date of Certificate June 16, 1937		Office of Registrar Boston, Mass.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

7238

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. STREET ADDRESS Cavetown	
3. NAME OF DECEASED (Type or print) First Emma Middle Beard Last Beard		4. DATE OF DEATH Month June Day 29 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1867
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co., Md.	
11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary Cline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hoy D. Newman, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and general atherosclerosis DUE TO (c) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - lobar		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14, 1959 , to June 29, 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 212 W. Washington St. Hagerstown, Md. DATE SIGNED 6/30/59			
ACTUAL SIGNATURE Edward W. Ditto M.D.			
PHYSICIAN'S NAME (Type) Edward W. Ditto 111 M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg, Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. ...			

CERTIFICATE OF DEATH

1234

NAME OF DECEASED JAMES H. SMITH		SEX Male	
DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION LABORER		MARITAL STATUS Single	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH Natural	
TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	
CITY OF BALTIMORE		COUNTY OF BALTIMORE	
STATE OF MARYLAND		YEAR 1900	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7239

CERTIFICATE OF DEATH

Reg. Dist. No.

07229

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>Baker</u> Last <u>Bernhart</u>		4. DATE OF DEATH Month <u>June 1,</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Department of Highway</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lewisburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Bernhart</u>		14. MOTHER'S MAIDEN NAME <u>Lena Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-12-8660A.</u>	
17. INFORMANT <u>Mrs. Carolyn Bernhart, Blue Ridge Summit Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c) <u>6 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis; Senile Maculatus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-10</u> , 19 <u>59</u> , to <u>6-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-1</u> , 19 <u>59</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>998 Potomac Ave.</u> DATE SIGNED <u>6-2-59</u>			
ACTUAL SIGNATURE <u>Dalton M. Walby</u> M.D.		PHYSICIAN'S NAME (Type) <u>DALTON M. Walby</u> <u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lewisburg</u>		22d. LOCATION (City, town, or county) (State) <u>Lewisburg, Union Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7240

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07230
302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 7 Wks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 d. STREET ADDRESS Hebb Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MYRTLE BLOOM		4. DATE OF DEATH Month Day Year June 10 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 23 1889
9. AGE (In years lost birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Moats	
14. MOTHER'S MAIDEN NAME Susan Fitch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Milton R. Bloom Hagerstown Md. R # 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip & Left Clavicle 904.0 DUE TO: (b) Arterio-sclerotic Heart Disease (c) Generalized Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic Agitation		INTERVAL BETWEEN ONSET AND DEATH April 3-59	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes at home - just slipped		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 10 Hour o. m. April 23 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Wash. Md.	
21. I certify that I attended the deceased from April 10, 1959 , to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at 6:50 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sidney Nowbotten M.D. Hagerstown Md. 6-11-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59	
22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kears			

FOR STATE
HEALTH DEPT.

7294

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		d. STREET ADDRESS 24 W. Potomac Street	
3. NAME OF DECEASED (Type or print) First Harry Middle Franklin Last Bowman		4. DATE OF DEATH Month June Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR: Months 8 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	11. BIRTHPLACE (State or foreign country) Lurray Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME Thomas Bowman	
14. MOTHER'S MAIDEN NAME Mary Putter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 216 07 6991		17. INFORMANT Bertha Mae Bowman Address 24 W. Potomac St. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by drowning DUE TO 850.X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Drowned when boat upset while fishing	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour XXXX 3:50 p. m. June 3 19 59	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Williamsport, (County) Wash (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Lee		24a. REC'D BY REGISTRAR June 9 '59	
		24b. REGISTRAR'S SIGNATURE Ciribon S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7295

CERTIFICATE OF DEATH

Reg. Dist. No.

07232

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2425 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle MARY Last BREWBAKER		4. DATE OF DEATH Month June 13, Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Franklin County, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Miller		14. MOTHER'S MAIDEN NAME Elizabeth Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Laura Brewbaker		Address 2425 Penna. Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enter trochanteric fracture 1957			INTERVAL BETWEEN ONSET AND DEATH Two years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 59 , to June 13 , 19 59 , that I last saw the deceased alive on June 6 , 19 59 , and that death occurred at 9:15 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Vh Campbell		ADDRESS (Street, city or town, state) DATE SIGNED 145 W Washington St 6/15/59	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1959	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Stark O-then.		ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

1

Op

11-23-35

STATE OF NEW YORK
DEPARTMENT OF HEALTH

11-23-35

[Faint, mostly illegible text and lines forming a form structure, likely a death certificate or medical record.]



11-23-35

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7296

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07233

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, R #3		c. LENGTH OF STAY IN 1b 24 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharpsburg Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Ullum Last Brill		4. DATE OF DEATH Month June Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Mineral 6th., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Ullum		14. MOTHER'S MAIDEN NAME Susan Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Lewis R. Brill, R. #3, Hagerstown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1-1959 to 6-28-1959 , that I last saw the deceased alive on 6-27-59 , 19 59 , and that death occurred at 3 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. W. Ditt		ADDRESS (Street, city or town, state) Hagerstown, Md	
PHYSICIAN'S NAME (Type) F. W. Ditt		DATE SIGNED 6-29-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/1959	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Bakersville, Wash. Cty., Md
23. FUNERAL DIRECTOR'S SIGNATURE A. K. Coffman, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knaul	

MARYLAND STATE DEPARTMENT OF HEALTH
Baltimore
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
31. Signature of Burial		32. Signature of Interment		33. Signature of Burial	
34. Signature of Interment		35. Signature of Burial		36. Signature of Interment	
37. Signature of Burial		38. Signature of Interment		39. Signature of Burial	
40. Signature of Interment		41. Signature of Burial		42. Signature of Interment	
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46. Signature of Interment		47. Signature of Burial		48. Signature of Interment	
49. Signature of Burial		50. Signature of Interment		51. Signature of Burial	
52. Signature of Interment		53. Signature of Burial		54. Signature of Interment	
55. Signature of Burial		56. Signature of Interment		57. Signature of Burial	
58. Signature of Interment		59. Signature of Burial		60. Signature of Interment	
61. Signature of Burial		62. Signature of Interment		63. Signature of Burial	
64. Signature of Interment		65. Signature of Burial		66. Signature of Interment	
67. Signature of Burial		68. Signature of Interment		69. Signature of Burial	
70. Signature of Interment		71. Signature of Burial		72. Signature of Interment	
73. Signature of Burial		74. Signature of Interment		75. Signature of Burial	
76. Signature of Interment		77. Signature of Burial		78. Signature of Interment	
79. Signature of Burial		80. Signature of Interment		81. Signature of Burial	
82. Signature of Interment		83. Signature of Burial		84. Signature of Interment	
85. Signature of Burial		86. Signature of Interment		87. Signature of Burial	
88. Signature of Interment		89. Signature of Burial		90. Signature of Interment	
91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

7297

07234

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HUBERT WILLIAM BRINING</u>				4. DATE OF DEATH Month Day Year <u>JUNE 2 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 11 - 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER - NORMAN S. EARLEY - CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEAVER CREEK WASH. CO. MD. U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM BRINING</u>				14. MOTHER'S MAIDEN NAME <u>KATIE RUDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-3573</u>		17. INFORMANT <u>MRS. WILBOR SWOPE HAGERSTOWN MD. R.I.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio vascular disease</u> DUE TO <u>5 yrs.</u> (c) <u>Tuberculosis-pulmonary</u> <u>2 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>102X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-29-58</u> 19 , to <u>6-2-59</u> 19 , that I last saw the deceased alive on <u>11-12-58</u> 19 , and that death occurred at <u>4:30A</u> M , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u>				ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u>		DATE SIGNED <u>6-2-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE-4-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 8 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

FROM

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

OCCUPATION

EDUCATION

Marital Status

Previous Illnesses

Signature of Physician

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7241

CERTIFICATE OF DEATH

07235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 647 W. Washington St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis Garfield Charles		4. DATE OF DEATH Month June Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drill Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop	
11. BIRTHPLACE (State or foreign country) Near Clearspring Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rudolph Charles		14. MOTHER'S MAIDEN NAME Mary Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 279-09-0835	
INFORMANT Mrs. Nora E. Gehr		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pancreatitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22 , 19 59 , to June 29 , 19 59 that I last saw the deceased alive on June 28 , 19 59 , and that death occurred at 4 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George Jennings		M.D. 136 W. Washington St.	
PHYSICIAN'S NAME (Type) George Jennings		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORY Ridge Hill Mem Park		22d. LOCATION (City, town, or county) (State) Lorain Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Colman S. Kraus	

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CASE NO. 1000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNT Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 wks.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville 06 x-2		d. STREET ADDRESS Obiect Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ISAAC First ELDRIDGE Middle COSTLEY Last		4. DATE OF DEATH JUNE Month 29 Day 1959 Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1887
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua L. Costley		14. MOTHER'S MAIDEN NAME Martha Dykes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-14-1261	
17. INFORMANT Mrs. Ada F. Costley,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMBOLUS, PULMONARY INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 WEEKS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 6 , 19 59 , to JUNE 29 , 19 59 , that I last saw the deceased alive on JUNE 29 , 19 59 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Lardizabal M.D.		ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE DATE SIGNED 6-30-59	
PHYSICIAN'S NAME (Type) EVARISTO R. LARDIZABAL		HAGERSTOWN MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-3-1959	22c. NAME OF CEMETERY OR CREMATORY White Rock	22d. LOCATION (City, town, or county) (State) Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thrall	

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1943

CERTIFICATE OF DEATH

11338

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DECEASED'S RESIDENCE: [illegible]
DECEASED'S OCCUPATION: [illegible]

DECEASED'S MARITAL STATUS: [illegible]
DECEASED'S RELIGION: [illegible]

DECEASED'S RACE: [illegible]
DECEASED'S COLOR: [illegible]

DECEASED'S SEX: [illegible]
DECEASED'S AGE: [illegible]

DECEASED'S DATE OF BIRTH: [illegible]
DECEASED'S PLACE OF BIRTH: [illegible]

DECEASED'S DATE OF DEATH: [illegible]
DECEASED'S PLACE OF DEATH: [illegible]

DECEASED'S CAUSE OF DEATH: [illegible]
DECEASED'S MANNER OF DEATH: [illegible]

DECEASED'S SIGNATURE: [illegible]
DECEASED'S ADDRESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7298

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u>		d. STREET ADDRESS <u>124 1/2 W. Franklin ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MAY</u> Last <u>CREBS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wm. Higman</u>		14. MOTHER'S MAIDEN NAME <u>Nannie V. Knode</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>315-14-1269</u>	
17. INFORMANT <u>Mrs. Vernon Beard - Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tabo-paresis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cystitis--pyelitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> , 19____, to <u>June 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>59</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Dr. W.T. Layman</u> M.D. <u>100 Professional Arts Bldg. 6/15/59</u> PHYSICIAN'S NAME (Type) <u>William T. Layman</u> <u>Hagerstown</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Woodford T. Normant - Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7243

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07238

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 Mulberry Ave.		d. STREET ADDRESS 915 Mulberry Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DONALD Middle RICHARD Last DAILEY, JR.		4. DATE OF DEATH Month June Day 22 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1954
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Donald R. Dailey, Sr.		14. MOTHER'S MAIDEN NAME Helen Nuna Kephart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Donald R. Dailey, Sr.		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 CONGESTIVE HEART FAILURE DUE TO (b) BRONCHO PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) MUCOVISCIDOSIS INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 week BIRTH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-20 , 19 54 , to 6-22 , 19 59 , that I last saw the deceased alive on 6-21 , 19 59 , and that death occurred at 2 A. M, from the causes and on the date stated above. ACTUAL SIGNATURE E. Margaret Sullivan M.D. ADDRESS (Street, city or town, state) 314 N. Potomac St. DATE SIGNED 6-22-59 PHYSICIAN'S NAME (Type) E. Margaret Sullivan, M. D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 25 '59		24b. REGISTRAR'S SIGNATURE Carlton S. House	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
BOSTON
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John A. Smith		45		Male		White	
Residence		Date of Death		Time of Death		Place of Death	
123 Main St., Boston, Mass.		October 11, 1914		10:30 A.M.		Home	
Cause of Death		Disease		Duration		Manner of Death	
Myocardial Infarction		Coronary Atherosclerosis		One Week		Natural	
Immediate Cause		Contributing Cause		Occupation		Education	
Myocardial Infarction		Hypertension		Clerical		High School	
Physician		Medical Examiner		Burial Place		Burial Date	
Dr. J. B. Brown		Dr. J. B. Brown		Catholic Cemetery, Boston		October 15, 1914	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 231 Taylor Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE VIOLA DAVIS				4. DATE OF DEATH Month Day Year June 12 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1884		
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 7 4		IF UNDER 24 HRS. Months Days Hours Min. 12 19 59				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Knitter			10b. KIND OF BUSINESS OR INDUSTRY Knitting mill		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Anna Hose				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Margie St. John Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus, bilateral 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Phlebothrombosis, iliac DUE TO (c) less than 8 da							INTERVAL BETWEEN ONSET AND DEATH 27 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease; cholecystitis; cholelithiasis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		
20f. (City or town) -----				20g. (County) -----		20h. (State) -----		
21. I certify that I attended the deceased from March 19 59 to June 12 19 59 , that I last saw the deceased alive on June 11 19 59 , and that death occurred at 8:12A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 North Potomac Street, Hagerstown, Md. DATE SIGNED 6-12-59								
ACTUAL SIGNATURE Robert F. Keadle M.D.								
PHYSICIAN'S NAME (Type) Robert F. Keadle				318 North Potomac Street, Hagerstown, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) St. Paul's Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home William H. Suter				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '59		
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines				

7244

07239

081

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2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1911

Washington

John Davis

John Davis

Washington County, Maryland

1111 Taylor Ave.

WHITE

WHITE

Male

Male

English

English

John Davis

John Davis

born

Mrs. Mary E. John Davis, Md.

THE CAUSE OF DEATH WAS

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Heart Failure

Maryland

Maryland

Maryland

Maryland

Maryland

Maryland

Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7245

CERTIFICATE OF DEATH

07240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>16 Hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>A.</u> Last <u>DEAL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> , Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1914</u>
9. AGE (In years lost birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>	
11. BIRTHPLACE (State or foreign country) <u>Smithsburg #2 Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel A. Deal</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Kipe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>188-09-5301</u>	
17. INFORMANT <u>Mrs. Edward A. Deal, Smithsburg #5, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC DIVERTICULITIS of THE</u> DUE TO (c) <u>Sigmoid Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sigmoid Colectomy</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 HR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. <u>m.</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 5</u> , 19 <u>59</u> , to <u>JUNE 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 26</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Moran</u>		ADDRESS (Street, city or town, state) <u>215 W Washington</u>	
PHYSICIAN'S NAME (Type) <u>JOHNA. MORAN</u>		DATE SIGNED <u>6/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hove</u>		ADDRESS <u>Waynesboro, Pa</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hove</u>	

CERTIFICATE OF DEATH

7542

1. NAME OF DECEASED MARTIN, JOHN		2. SEX M		3. AGE 45		4. DATE OF BIRTH JAN 15 1900	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE JUN 10 1925	
9. PRESENT RESIDENCE 1234 E. BALTIMORE AVE BALTIMORE, MD		10. CAUSE OF DEATH Heart Disease		11. PLACE OF DEATH Home		12. DATE OF DEATH DEC 10 1945	
13. SIGNATURE OF PHYSICIAN J. H. SMITH		14. SIGNATURE OF REGISTRAR J. H. SMITH		15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF DECEASED J. H. SMITH	
17. SIGNATURE OF NEXT OF KIN J. H. SMITH		18. SIGNATURE OF CLERK J. H. SMITH		19. SIGNATURE OF DECEASED J. H. SMITH		20. SIGNATURE OF DECEASED J. H. SMITH	

1

7246

CERTIFICATE OF DEATH

07241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Hospital		d. STREET ADDRESS 417 Clarendon Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle Butts Last DeHaven		4. DATE OF DEATH Month June Day 4 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 3 Days 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Berkeley Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas H. Butts		14. MOTHER'S MAIDEN NAME Saloma Albright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Olive Manford		Address 417 Clarendon Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular fibrillation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic and Hypertensive cardiovascular disease. DUE TO vascular disease. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of sigmoid suspected but not proved.			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 17 , 19 54 , to June 4 , 19 59 , that I last saw the deceased alive on June 4 , 19 59 , and that death occurred at 10:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) DATE SIGNED 100 Professional Arts Bldg. 6/6/59	
PHYSICIAN'S NAME (Type) William T. Layman		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/7/59	22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. Brown</i>		ADDRESS Martinsburg W.Va.	
24a. REC'D BY REGISTRAR JUN 8 '59		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

Washington

Washington

6 years

Washington

Belmont County Hospital

455 Cleveland Ave.

Male

White

Single

June 1948

Female

White

Married

March 1, 1952

77

3

Home

Home

Belmont Co. W.Va.

Miss M. H. H. H.

Belmont Hospital

Miss M. H. H. H.

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Belmont County Hospital

77

Female

Belmont County Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G244 6-22-59 et

7247

CERTIFICATE OF DEATH

Reg. Dist. No.

07242
302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Mo d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 930E Main Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle BURNS Last DELOSIER		4. DATE OF DEATH Month June Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 10 1865
9. AGE (In years last birthday) 93 9/16 yrs.		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 00 Min. 00	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Tracey		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Lillian Brown		Address 930E Main Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 331X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) 3 wks.		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17 , 19 59 , to June 13 , 19 59 , that I last saw the deceased alive on May 12 , 19 59 , and that death occurred at 10:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 N. Potomac Street, Hagerstown, Maryland DATE SIGNED 6/15/59			
ACTUAL SIGNATURE D. J. Boyer		M.D. D. J. Boyer	
PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/16/59	22c. NAME OF CEMETERY OR CREMATORY Bethel U.B. Cemetery	22d. LOCATION (City, town, or county) (State) Foxville Fred. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

733

ANNOUNCED

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1945-10-15	
Place of Birth		Race		Occupation		Cause of Death	
New York City		White		Teacher		Heart Disease	
Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Natural		[Signature]		[Signature]		[Signature]	
Certified True and Correct		Date		Place		Signature of Registrar	
[Signature]		1945-10-16		Baltimore, Md.		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7248

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07243

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle DRAGER Last DRAGER		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Grief		14. MOTHER'S MAIDEN NAME Mary Seegnuber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Rev. Mark Wagner		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart exhaustion + collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiovascular. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29, 19 59 to June 30, 19 59 , that I last saw the deceased alive on June 30, 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Louis G. Graff M.D. Hagerstown Md 7/1/59			
ACTUAL SIGNATURE Louis G. Graff		M.D.	
PHYSICIAN'S NAME (Type) Louis G. GRAFF M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore, Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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• *Journal of Management Education*

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7249

CERTIFICATE OF DEATH

07244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1164 Hamilton Blvd.		d. STREET ADDRESS 1164 Hamilton Blvd.	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle LINWOOD Last DUNHAM		4. DATE OF DEATH Month JUNE Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months 6 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Woolen Co.	
11. BIRTHPLACE (State or foreign country) Berkeley Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Washington Taylor Dunham		14. MOTHER'S MAIDEN NAME May Catherine Pine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None.	
17. INFORMANT Willie Frank Dunham 1164 Hamilton Blvd., Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) Years.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 21, 1959 , to June 26, 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 4:30AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.A. Bell		ADDRESS (Street, city or town, state) 119 North Potomac Street. DATE SIGNED 6-26-59	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-1959	22c. NAME OF CEMETERY OR CREMATORY New Norborne Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg, West Va.
23. FUNERAL DIRECTOR'S SIGNATURE Howard N. Brown		ADDRESS Martinsburg, W. Va.	
24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. H. 110	

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CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G243 6-11-59 et

CERTIFICATE OF DEATH

07245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>43 West Baltimore St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George L. Etter</u>				4. DATE OF DEATH Month Day Year <u>June 5, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/14/1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Etter</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hollinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unable to obtain</u>			
17. INFORMANT <u>Mr. Anson Etter</u> Address <u>State Line, Pa</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>199.2</u> DUE TO (Primary site undeterminable) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Note: Proved by laparotomy & biopsy</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-1-</u> , 19 <u>39</u> , to <u>6-5-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-4-59</u> , 19 <u>59</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Brewer</u>				ADDRESS (Street, city or town, state) <u>359 E. Baltimore St., Greencastle, Pa.</u>			
DATE SIGNED <u>6-5-59</u>							
PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>				<u>359 E. Baltimore St., Greencastle, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethren Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle, Pa</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

CERTIFICATE OF DEATH

COUNTY OF CLATSOP STATE OF OREGON		DECEASED NAME	
PLACE OF BIRTH DATE OF BIRTH		SEX RACE	
PLACE OF DEATH DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH MANNER OF DEATH		MEDICAL HISTORY	
PRESENTING SYMPTOMS HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION LABORATORY EXAMINATIONS	
TREATMENT PROGNOSIS		POSTMORTEM EXAMINATION CAUSE OF DEATH	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF CORONER DATE	
SIGNATURE OF WITNESS DATE		SIGNATURE OF JURY DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7251

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07246

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spring Grove 75x-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIE Middle B. Last FAUST				4. DATE OF DEATH Month June Day 27 Year 1959					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1876			
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) U.S.A.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Edwin H. Bickel				14. MOTHER'S MAIDEN NAME Sarah Amanda Scholl					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Rev. Mark Wagner Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident DUE TO Cholesterolosis of Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. DUE TO (c) hyp.								INTERVAL BETWEEN ONSET AND DEATH Days Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 26 , 19 59 , to June 27 , 19 59 , that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 11:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam 62959 DATE SIGNED 6/29/59 ACTUAL SIGNATURE Louis S. Graff M.D. PHYSICIAN'S NAME (Type) Louis S. Graff Hagerstown Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/1959		22c. NAME OF CEMETERY OR CREMATORY Leschey's Union Cemetery		22d. LOCATION (City, town, or county) (State) York County, Pennsylvania			
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Poyner				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1931
CERTIFICATE OF DEATH

Date of Death 1931		Place of Death Baltimore		Age 7 years		Sex Male		Race White		Marital Status Single		Occupation None		Cause of Death Scarlet Fever		Place of Birth Baltimore		Date of Birth May 13, 1924		Name of Deceased Harold Amos Schell		Name of Informant Rev. Frank Warner		Signature of Informant (Signature)		Signature of Registrar (Signature)		Signature of Physician (Signature)	
Date of Death 1931		Place of Death Baltimore		Age 7 years		Sex Male		Race White		Marital Status Single		Occupation None		Cause of Death Scarlet Fever		Place of Birth Baltimore		Date of Birth May 13, 1924		Name of Deceased Harold Amos Schell		Name of Informant Rev. Frank Warner		Signature of Informant (Signature)		Signature of Registrar (Signature)		Signature of Physician (Signature)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7252

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07247

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Jefferson St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last FAVORITE		4. DATE OF DEATH Month June Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27 1874
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R.H. Fouke		14. MOTHER'S MAIDEN NAME Delilah Clugston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Mary ³/₄ A. Brenner		Address 311 Jefferson St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis to lungs and liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c) Arteriosclerotic myocardial heart failure grade iv		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Oct. 1953 to June 30 1959 , that I last saw the deceased alive on June 30 1959 , and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Robert Wells		ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 7-1-59	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUL 7 59		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

7299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Boonsboro</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll Co</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amanda Elizabeth Garner</u>		4. DATE OF DEATH Month Day Year <u>June 28 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Myers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Ruth H. Swander Union Bridge</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2 1959</u> , to <u>June 28 1959</u> , that I last saw the deceased alive on <u>June 26 1959</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.		ADDRESS (Street, city or town, state) <u>Boonsboro Md</u> DATE SIGNED <u>6/28/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-30-1959</u>	<u>Meadow Branch</u>	<u>Near Westminster Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond K. Wright Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7253

CERTIFICATE OF DEATH

07249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> 02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(Isabel) ISABELLE BOWEN</u> Middle Last				4. DATE OF DEATH <u>JUNE 11</u> 19 <u>59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Steelberg</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-26-5047</u> Address <u>Mr. Robert Mouat, 400 E. 30th Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Hepatic COMA</u> DUE TO (b) <u>Portal Cirrhosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenic purpura, Rheumatic Heart Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>JUNE 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 11</u> , 19 <u>59</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.				ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> DATE SIGNED <u>6-11-59</u>			
PHYSICIAN'S NAME (Type) <u>Evaristo R. Lardizabal</u> <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Huns</u>	

MEDICAL CERTIFICATION

2

1

DP

11554

STANDARD STATE PRINTING CO. - BALTIMORE, MD.

CERTIFICATE OF DEEDS

1353



NOTARY PUBLIC

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7300

CERTIFICATE OF DEATH

07250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Gateway Nursing Home		e. STREET ADDRESS 17 N. Locust St.	
3. NAME OF DECEASED (Type or print) First Bertha Middle Nora Last Grove		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 20, 1880
9. AGE (In years birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Nichols		14. MOTHER'S MAIDEN NAME Mary Boward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Robert H. Grove, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/29/59 to 6/30/59 , that I last saw the deceased alive on 6/30/59 , and that death occurred at 4:30 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 6/7/59	
ACTUAL SIGNATURE Ralph L. Young		PHYSICIAN'S NAME (Type) William H. ...	
22a. BURIAL, CREMATION, or other disposition (Specify) burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. ...			

WY530

CENTRAL OF MARY

7200

1928

10.

Washington

Washington

July 1, 1928

Primary Nursing Home

June 30, 1928

Home

White, July 20, 1928

Washington, D.C.

John Nichols

Robert A. Brown, Englewood, N.Y.

Part 1, 7-2-28

John A. Nichols, Englewood, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
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VS A15 (4)
15M 9/58

7254

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 1/2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle (NONE) Last GROVE		4. DATE OF DEATH Month June Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Lived with brother	
11. BIRTHPLACE (State or foreign country) Frederick County, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Grove		14. MOTHER'S MAIDEN NAME Sally Duffey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Marshall Grove		Address Hagerstown, Md. R#2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - terminal - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis and DUE TO arteriosclerotic heart disease (c) arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 9, 1959 , to June 10, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at 12:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Maryland DATE SIGNED 6-11-59 ACTUAL SIGNATURE Edward W. Ditto M.D. PHYSICIAN'S NAME (Type) Edward W. Ditto 111 M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 13, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Winchester Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

Wm. G. Horak U-Proc.

525

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7255

CERTIFICATE OF DEATH

07252

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL First LESTER Middle GUESSFORD Last		4. DATE OF DEATH Month June Day 6 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1913
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 10 Days 20	11. IF UNDER 24 HRS. Hours 10 Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Guessford		14. MOTHER'S MAIDEN NAME Stella Rubeck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) in the 30's		16. SOCIAL SECURITY NO. 220-10-3193	
17. INFORMANT Mrs. Bertha Guessford		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulonephritis with Hypertension DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 59 , to June 6 , 19 59 , that I last saw the deceased alive on June 6 , 19 59 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Archie R. Cohen M.D.		DATE SIGNED 6/7/59	
PHYSICIAN'S NAME (Type) Archie R. Cohen M.D.		Address Clearspring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Kouzer Funeral Home Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
24b. REGISTRAR'S SIGNATURE Calvin S. Evans			

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form No. 102

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1900		New York City	
Cause of Death		Disease		Organ		Site		Nature	
Heart Disease		Coronary Artery		Sclerosis		Myocardial		Infarction	
Date of Death		Time of Death		Place of Death		Occupation		Habitual Residence	
Jan 15, 1935		10:00 AM		Home		Teacher		New York City	
Physician		Attending Physician		Medical Examiner		Coroner		Burial Place	
Dr. Smith		Dr. Jones		Dr. Brown		Dr. White		Cemetery	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Burial Place		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

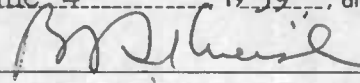
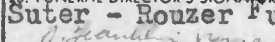
7256

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07253

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MC CAMMON Last HARTMAN		4. DATE OF DEATH Month June Day 4 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1913
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Calvin B. Hartman		14. MOTHER'S MAIDEN NAME Florence E. Metzger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-09-6016	
17. INFORMANT Edward L. Hartman		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic hydronephrosis with renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive vascular disease and cardiac enlargement			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____ 19 56 , to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St. Hagerstown, Maryland DATE SIGNED 6/5/59			
ACTUAL SIGNATURE 		M.D. B. B. Kneisley, M.D.	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7301

CERTIFICATE OF DEATH

07254

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#6		c. LENGTH OF STAY IN 1b 6 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reid		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM OWEN HENDRICKSON		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27 1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Express Co	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy Hendrickson		14. MOTHER'S MAIDEN NAME Anna May Shuckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-4969	
17. INFORMANT Mrs Dorothy K. Hendrickson		Address Hagerstown R # 6 Md Reid	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July , 19 56 , to June 17 , 19 59 , that I last saw the deceased alive on June 1 , 19 59 , and that death occurred at 10 30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Harrison		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____		M.D. _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

7257

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 244 7-8-59 et

CERTIFICATE OF DEATH

07255

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Hagerstown Webster Grove 62X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS 325 Newport Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH HELEN MARTHA HERMANN				4. DATE OF DEATH Month Day Year June 21 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1884	
9. AGE (In years and birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min. 74		11. IF UNDER 24 HRS. Months Days Hours Min. 74		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Florist				10b. KIND OF BUSINESS OR INDUSTRY Florist		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles M. Hermann				14. MOTHER'S MAIDEN NAME Elizabeth Diehl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Address Homewood Church Home, Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular Accident DUE TO Gen. arteriosclerosis (c) Gen. arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Days Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 16, 1959 to June 21, 1959 that I last saw the deceased alive on June 19, 1959 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) 119 E. Antietam Hagerstown Md. DATE SIGNED 6/22/59							
ACTUAL SIGNATURE Louis G. GRAFF M.D.				PHYSICIAN'S NAME (Type) Louis G. GRAFF			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
October 10, 1950		Home		Heart Disease	
Time of Death		Physician		Hospital	
10:00 AM		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Address of Deceased		City		State	
123 Main St		Baltimore		MD	
Occupation		Education		Marital Status	
Teacher		High School		Married	
Previous Illnesses		Previous Injuries		Previous Operations	
None		None		None	
Burial Place		Burial Date		Burial Time	
St. Mary's Cemetery		October 12, 1950		11:00 AM	
Burial Place		Burial Date		Burial Time	
St. Mary's Cemetery		October 12, 1950		11:00 AM	
Signature of Registrar		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	
Address of Registrar		Address of Coroner		Address of Physician	
123 Main St		123 Main St		123 Main St	
City		City		City	
Baltimore		Baltimore		Baltimore	
State		State		State	
MD		MD		MD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07256

7302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RENO Middle LESTER Last HETZEL		4. DATE OF DEATH Month June 13, Day 13 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 3 Min.	11. IF UNDER 24 HRS. Months 3 Days 15 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tester		10b. KIND OF BUSINESS OR INDUSTRY Freezer Mfg. Plant	
11. BIRTHPLACE (State or foreign country) Antietam, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Hetzel		14. MOTHER'S MAIDEN NAME Susan Jamison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-10-3783	
17. INFORMANT Mrs. Etta Va. Hetzel R.F.D.#1, Harpers Ferry, West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, cerebral 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease DUE TO (c) 15 years		INTERVAL BETWEEN ONSET AND DEATH 3 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1953 , to May 10, 1957 , that I last saw the deceased alive on May 10, 1957 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 206 W. Liberty St., Charles Town, W. Va. DATE SIGNED June 12, 1959			
ACTUAL SIGNATURE Donald K. McIntyre M.D.		DATE SIGNED June 12, 1959	
PHYSICIAN'S NAME (Type) DONALD K. MCINTYRE, M.D.		206 W. Liberty St., Charles Town, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/59	
22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Samples Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Cackles		ADDRESS Harpers Ferry, West Va.	
24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

7258

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle D Last Hicks				4. DATE OF DEATH Month 6 Day 7 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Lawyer		11. BIRTHPLACE (State or foreign country) Wash. Co.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cadmus M. Hicks				14. MOTHER'S MAIDEN NAME Mary Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Address Mrs. Florence Hicks Sharpsburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 6/7, 19 59 , to 6/7, 19 59 , that I last saw the deceased alive on 6/7, 19 59 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington Street DATE SIGNED 6:8:59							
ACTUAL SIGNATURE John H. Hornbaker M.D.							
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-10-59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

UNITED STATES DEPARTMENT OF AGRICULTURE

1918

WASHINGTON

February 1, 1918

Dear Sir:

I have

been

very busy

and

am sorry

to

be unable

to attend

to

the meeting

on

February 1st

and

am sorry

to

be unable

to

attend

the

meeting

on

February 1st

and

am sorry

to

be unable

to

attend

the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07258

7259

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL EDWARD HORNBAKER		4. DATE OF DEATH Month Day Year June 5 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1881
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (State or foreign country) St. James, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Zachery Taylor Hornbaker	
14. MOTHER'S MAIDEN NAME Elizabeth Carbaugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Elton Hornbaker Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral hemorrhage DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia + pleural effusion, emphysema INTERVAL BETWEEN ONSET AND DEATH 3 days year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10/56 , 19____, to 6/5/59 , 19____, that I last saw the deceased alive on 6/4/59 , 19____, and that death occurred at 1:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard N. Weeks		ADDRESS (Street, city or town, state) 136 North Potomac St. Hagerstown, Maryland	
DATE SIGNED 6/5/59		M.D. Howard N. Weeks, M.D.	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Fouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1900

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		White		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1900		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology	
New York		Jan 1, 1855		Jan 10, 1900		Jan 12, 1900		Jan 15, 1900		Jan 16, 1900		Jan 17, 1900		Jan 18, 1900		Jan 19, 1900		Jan 20, 1900		Jan 21, 1900		Jan 22, 1900		Jan 23, 1900		Jan 24, 1900		Jan 25, 1900	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Histology		Date of Cytology	
Home		Jan 15, 1900		Jan 16, 1900		Jan 17, 1900		Jan 18, 1900		Jan 19, 1900		Jan 20, 1900		Jan 21, 1900		Jan 22, 1900		Jan 23, 1900		Jan 24, 1900		Jan 25, 1900		Jan 26, 1900		Jan 27, 1900		Jan 28, 1900	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Histology		Date of Cytology	
Heart Disease		Jan 15, 1900		Jan 16, 1900		Jan 17, 1900		Jan 18, 1900		Jan 19, 1900		Jan 20, 1900		Jan 21, 1900		Jan 22, 1900		Jan 23, 1900		Jan 24, 1900		Jan 25, 1900		Jan 26, 1900		Jan 27, 1900		Jan 28, 1900	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Histology		Date of Cytology	
Home		Jan 15, 1900		Jan 16, 1900		Jan 17, 1900		Jan 18, 1900		Jan 19, 1900		Jan 20, 1900		Jan 21, 1900		Jan 22, 1900		Jan 23, 1900		Jan 24, 1900		Jan 25, 1900		Jan 26, 1900		Jan 27, 1900		Jan 28, 1900	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microscopic		Date of Bacteriology		Date of Pathology		Date of Histology		Date of Cytology	
Heart Disease		Jan 15, 1900		Jan 16, 1900		Jan 17, 1900		Jan 18, 1900		Jan 19, 1900		Jan 20, 1900		Jan 21, 1900		Jan 22, 1900		Jan 23, 1900		Jan 24, 1900		Jan 25, 1900		Jan 26, 1900		Jan 27, 1900		Jan 28, 1900	



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VS A15 (4)
ISM 9/58

7303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 3½ Mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hagerstown		d. STREET ADDRESS R#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RENA Middle ALICE Last HOUSER		4. DATE OF DEATH Month June Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josephus Wise		14. MOTHER'S MAIDEN NAME Susan Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Roy M. Houser R#3		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Dis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1959 to June 13, 1959 that I lost saw the deceased alive on June 12, 1959 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 6/15/59	
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Knaus			

Wm. C. Host & Co. Pres.

105250

RECEIVED BY DEPT. OF STATE

105250

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
ISM 9/58

7260

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville, Lantz P.O.		10x-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Hurley		4. DATE OF DEATH Month June Day 10 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1887
9. AGE (In years and birth day) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Hurley		14. MOTHER'S MAIDEN NAME Genora Draper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-1124	
INFORMANT Catherine Lewis Hurley		Address Lantz, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 466x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis of left iliac vein DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-4 , 19 57 , to 6-10 , 19 59 , that I last saw the deceased alive on 6-10 , 19 59 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 6-11-59			
ACTUAL SIGNATURE Charles F. Hess		M.D. Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		22d. LOCATION (City, town, or county) (State) nr. Garfield Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1980

Register

Maryland

Washington

For a full list of deaths, see the

Washington County Hospital

Washington County Hospital

1

June 10, 1980

Harley

C.

Charles

March 24, 1980

X

White

Male

U.S.A.

Maryland

Gen Farm

Farmer

Genora Greger

Wilson Hume

Janet, Md.

Catherine Davis Harley

1980-3-11

no

The following is a list of deaths reported to the

Washington County Health Department

For a full list of deaths, see the

Maryland

St. Charles

Health Department

1980-1-10

Thurmont, Maryland

Farmer

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07261

7304

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Page	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LuRay 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		d. STREET ADDRESS unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLETUS Middle ORVILLE Last KENDRICK		4. DATE OF DEATH Month June Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Tannery	11. BIRTHPLACE (State or foreign country) LuRay, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jack Kendrick		14. MOTHER'S MAIDEN NAME Rosie Belle Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-4761	
17. INFORMANT James O. Kendrick		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1959 , to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 12:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 6/5/59	
PHYSICIAN'S NAME (Type) David Brewer		Clearspring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Super-Houzer Funeral Home <i>R. Lankford</i>		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 10/57

7261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 So Potomac St		d. STREET ADDRESS 1100 So Potomac St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARVEY DENTON KLINE		4. DATE OF DEATH Month June Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kline		14. MOTHER'S MAIDEN NAME Ann McDonough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5994	
17. INFORMANT Mrs Frances Kline		Address 1100 So Potomac St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 16 mo INTERVAL BETWEEN ONSET AND DEATH 3 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15 , 19 59 , to 6-13 , 19 59 , that I last saw the deceased alive on 6-1-59 , 19 59 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Hagerstown Md	
DATE SIGNED 6/13/59			
PHYSICIAN'S NAME (Type) DREW H. T. To			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7262

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07263

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital	
d. STREET ADDRESS 1617 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nora First Viola Kuhn Last		4. DATE OF DEATH Month June Day 30 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1890
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dallas Ward		14. MOTHER'S MAIDEN NAME Ida Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-38-8720	
INFORMANT Mrs. Ruth Landis, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastasis - 153.8 DUE TO post-operative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Two weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-16 , 19 59 , to 6-30 , 19 59 , that I last saw the deceased alive on 6-30 , 19 59 , and that death occurred at 4:29 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George Jennings		ADDRESS (Street, city or town, state) 136 W. Washington St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) George Jennings		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-3-59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Clear Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 59	
24b. REGISTRAR'S SIGNATURE John S. Minnich			

CERTIFICATE OF DEATH

1962

1017

1017

Washington

Washington

3 years

Washington

1017 Virginia Ave.

Washington County Hospital

June 30, 1962

June 30, 1962

June 30, 1962

June 30, 1962

1962

1962

1962

1962

Clear Spring, Md.

Clear Spring, Md.

Ida Smith

Ida Smith

1017 Virginia Ave., Washington, Md.

1017 Virginia Ave., Washington, Md.

1017

7263

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07264

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hosp.</u>		d. STREET ADDRESS <u>2703 Bounel Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Calvert Landon</u>		4. DATE OF DEATH Month Day Year <u>June 10 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1914</u>
9. AGE (In years lost birthday) <u>45 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Townson, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Sandon</u>		14. MOTHER'S MAIDEN NAME <u>Edythe Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONFLUENT lobular pneumonia, bilateral</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Cerebrospinal syphilis</u>		2. <u>Arteriosclerosis, generalized</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1959</u> , to <u>June 10, 1959</u> , that I last saw the deceased alive on <u>June 10, 1959</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor L. Ramos</u> M.D.		ADDRESS (Street, city or town, state) <u>Western Md. State Hospital, Hagerstown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Victor L. Ramos</u>		DATE SIGNED <u>June 10, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Cedar Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Kelso</u>		ADDRESS <u>1303 Washington</u>	
24a. REC'D BY REGISTRAR <u>DATE 6/12/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Davis</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
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FOR STATE HEALTH DEPT.

7264

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07265

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2006 Virginia Ave				d. STREET ADDRESS 2006 Virginia Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MINNIE Middle MILDRED Last LeFEVRE				4. DATE OF DEATH Month June Day 8 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 4 1880	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 7 Days 8	IF UNDER 24 HRS. Hours 8 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph B. Kneisley				14. MOTHER'S MAIDEN NAME Mary Cover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mary Shilling 2425 Jefferson Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) -	(County) -	(State) -		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-9-59			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/10/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			24a. REC'D BY REGISTRAR DATE JUN 11 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH OFF

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES D. BRYANT		45		M		W		JAN 15 1912	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 Vermont Ave		Clerk		Heart Failure		Natural		Home	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE	
JAN 15 1912		10:00 AM		Home		J. H. Smith		M.D.	
SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER		SIGNATURE OF CLERK		SIGNATURE OF JURY	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7265

CERTIFICATE OF DEATH

07266
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Smithsburg R # 2 d. STREET ADDRESS Chewsville e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RHODA HOOVER LEHMAN				4. DATE OF DEATH Month Day Year June 26 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 9 1903	
9. AGE (In years last birthday) yrs. 55		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Hoover		14. MOTHER'S MAIDEN NAME Linnie Lechrone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-2143		17. INFORMANT Harold F. Lehman Smithsburg Md R #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH minutes minutes minutes.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis General						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 59 , to June 26 , 19 59 that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 9 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 119 E. Antietam St. 6-27-59 Hagerstown, Md. ACTUAL SIGNATURE Louis G. Graff M.D. PHYSICIAN'S NAME (Type) Louis G. Graff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/59		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Haynesboro Franklin Co Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUL 6 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

1968

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of hospice	
19. Signature of other institution		20. Signature of other place		21. Signature of other person	
22. Signature of other person		23. Signature of other person		24. Signature of other person	
25. Signature of other person		26. Signature of other person		27. Signature of other person	
28. Signature of other person		29. Signature of other person		30. Signature of other person	
31. Signature of other person		32. Signature of other person		33. Signature of other person	
34. Signature of other person		35. Signature of other person		36. Signature of other person	
37. Signature of other person		38. Signature of other person		39. Signature of other person	
40. Signature of other person		41. Signature of other person		42. Signature of other person	
43. Signature of other person		44. Signature of other person		45. Signature of other person	
46. Signature of other person		47. Signature of other person		48. Signature of other person	
49. Signature of other person		50. Signature of other person		51. Signature of other person	
52. Signature of other person		53. Signature of other person		54. Signature of other person	
55. Signature of other person		56. Signature of other person		57. Signature of other person	
58. Signature of other person		59. Signature of other person		60. Signature of other person	
61. Signature of other person		62. Signature of other person		63. Signature of other person	
64. Signature of other person		65. Signature of other person		66. Signature of other person	
67. Signature of other person		68. Signature of other person		69. Signature of other person	
70. Signature of other person		71. Signature of other person		72. Signature of other person	
73. Signature of other person		74. Signature of other person		75. Signature of other person	
76. Signature of other person		77. Signature of other person		78. Signature of other person	
79. Signature of other person		80. Signature of other person		81. Signature of other person	
82. Signature of other person		83. Signature of other person		84. Signature of other person	
85. Signature of other person		86. Signature of other person		87. Signature of other person	
88. Signature of other person		89. Signature of other person		90. Signature of other person	
91. Signature of other person		92. Signature of other person		93. Signature of other person	
94. Signature of other person		95. Signature of other person		96. Signature of other person	
97. Signature of other person		98. Signature of other person		99. Signature of other person	
100. Signature of other person		101. Signature of other person		102. Signature of other person	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

7305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilson Md		c. LENGTH OF STAY IN 1b 3 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gateway Convalescent Home				d. STREET ADDRESS 428 Carrollton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jacob Last Loveless				4. DATE OF DEATH Month June Day 22 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26 1878		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 11 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		11. BIRTHPLACE (State or foreign country) Front Royal Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Harvey Loveless				14. MOTHER'S MAIDEN NAME Eliza Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-8849		17. INFORMANT Mr. Joseph Loveless Address 440 Carrollton Ave. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma rectum 154X DUE TO Arteriosclerotic myocardial heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour o. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) - (County) - (State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Wells				DATE SIGNED 6-24-59			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24-59		22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport Md				24a. REC'D BY REGISTRAR DATE JUN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Travis	

MEDICAL CERTIFICATION

2

7266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>SIX DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>MASON</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 17 - 1915</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC FINEFROIC FARMER SUPPLY CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PHILADELPHIA PENNA.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>HARRY MASON</u>				14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>220-16-2340</u>			
17. INFORMANT <u>MRS. FLORIDA MASON HAGERSTOWN</u>				Address <u>401 DAYCOTAH AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute carditis with dilatation</u> DUE TO <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRONCHITIS</u> DUE TO (c) <u>BRONCHITIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> , to <u>6/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>59</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown, Maryland</u> DATE SIGNED <u>6/19/59</u> ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 20 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

7306

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fiddlersburg</u> c. LENGTH OF STAY IN 1b <u>10 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>---</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fiddlersburg</u> d. STREET ADDRESS <u>---</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Jackson</u> Last <u>McAllister</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1906</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Archibald McAllister</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Suffecool</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. 2</u> (If yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>213-16-1352</u>		17. INFORMANT <u>Mrs. Susie Hull</u> Address <u>Hagerstown, Md. 425 Indiana Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Chronic severe asthma</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Compensatory emphysema</u> DUE TO (c) <u>Advanced TBC of lungs inactive</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> a. m. <u>19</u> p. m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>6-2-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/4/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	22d. LOCATION (City, town, or county) <u>nr. Clearspring, Wash. Cty.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7267

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 1139 E. ANTIETAM ST.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle ANN Last McKENNA		4. DATE OF DEATH Month JUNE Day 1 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1881
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 17 Hours 17 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHOE FINISHER		12. KIND OF BUSINESS OR INDUSTRY SHOE MFG. CO.	
13. BIRTHPLACE (State or foreign country) MARYLAND		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME JAMES P. McKENNA		16. MOTHER'S MAIDEN NAME SARAH ELLEN BOWERS	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 214-09-0559A	
19. INFORMANT MISS ALTRUDE McKENNA		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arrhythmia & Fibrillation DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1- , 19 59 , to 6-1-59 , 19 59 , that I last saw the deceased alive on 5-31-59 , 19 59 , and that death occurred at 7:50 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. DATE SIGNED 6-2-59			
ACTUAL SIGNATURE Paul Harrison M.D.		DATE 318 N. Potomac St.	
PHYSICIAN'S NAME (Type) Paul Harrison, M.D.		Address Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/3/59	
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. France	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7307

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport, c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A.— at office of Dr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 2229 Virginia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Vincent Last McKenna		4. DATE OF DEATH Month June Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1879
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Clearspring, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James P. McKenna	
14. MOTHER'S MAIDEN NAME Sarah Ellen Bowers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Madeline McKenna Address Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-11-59	22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery	22d. LOCATION (City, town, or county) (State) Western Pike -Hagerstown, Md
23. FUNERAL DIRECTOR'S SIGNATURE Normant J. Hone ADDRESS Hagerstown, Md		24a. REC'D BY REGISTRAR DATE JUN 11 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7308

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Items 18 & 21 Film #245- 7/23/59 - mb
CERTIFICATE OF DEATH

07272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN LENGTH OF STAY IN 1b 60YRS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK MEM. CONV. HOSP				d. STREET ADDRESS 139 E. ANTIETAM ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last McKENNA				4. DATE OF DEATH Month JUNE Day 27 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-11-1873	
9. AGE (In years last birthday) 85 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES P. McKENNA				14. MOTHER'S MAIDEN NAME SARAH ELLEN BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MISS ALTRUDE McKENNA, HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease, cerebral and generalized Indefinite DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to 6-27-59 , 19____, that I last saw the deceased alive on 6-26-59 , 19____, and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 7-6-59							
ACTUAL SIGNATURE Paul Harrison				M.D. 318 N. Potomac St. Hagerstown, Md.			
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-29-59		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR JUL 10 '59		24b. REGISTRAR'S SIGNATURE William S. Harris	

7309

CERTIFICATE OF DEATH

Reg. Dist. No.

07273

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 9 mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 1110 Corbett St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle VALENTINE Last MONG SR.		4. DATE OF DEATH Month June Day 28 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 16, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Foundry	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Mong		14. MOTHER'S MAIDEN NAME Rebecca Bowser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-5942	
INFORMANT Geo. V. Mong Jr. R#1 Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Valvular Dis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 8 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1958 , to June 28, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		DATE SIGNED 6/29/59	
PHYSICIAN'S NAME (Type) David R. Brewer		ADDRESS (Street, city & town, state) Clear Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funera l Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Thoms			

Wm. G. Stark & Sons.

THE STATE OF NEW YORK,
COUNTY OF ALBANY,
ss. I, the undersigned, Clerk of the said County, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of the said County.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said County, at Albany, this 1st day of January, 1887.

CLERK OF THE COUNTY OF ALBANY.

7268

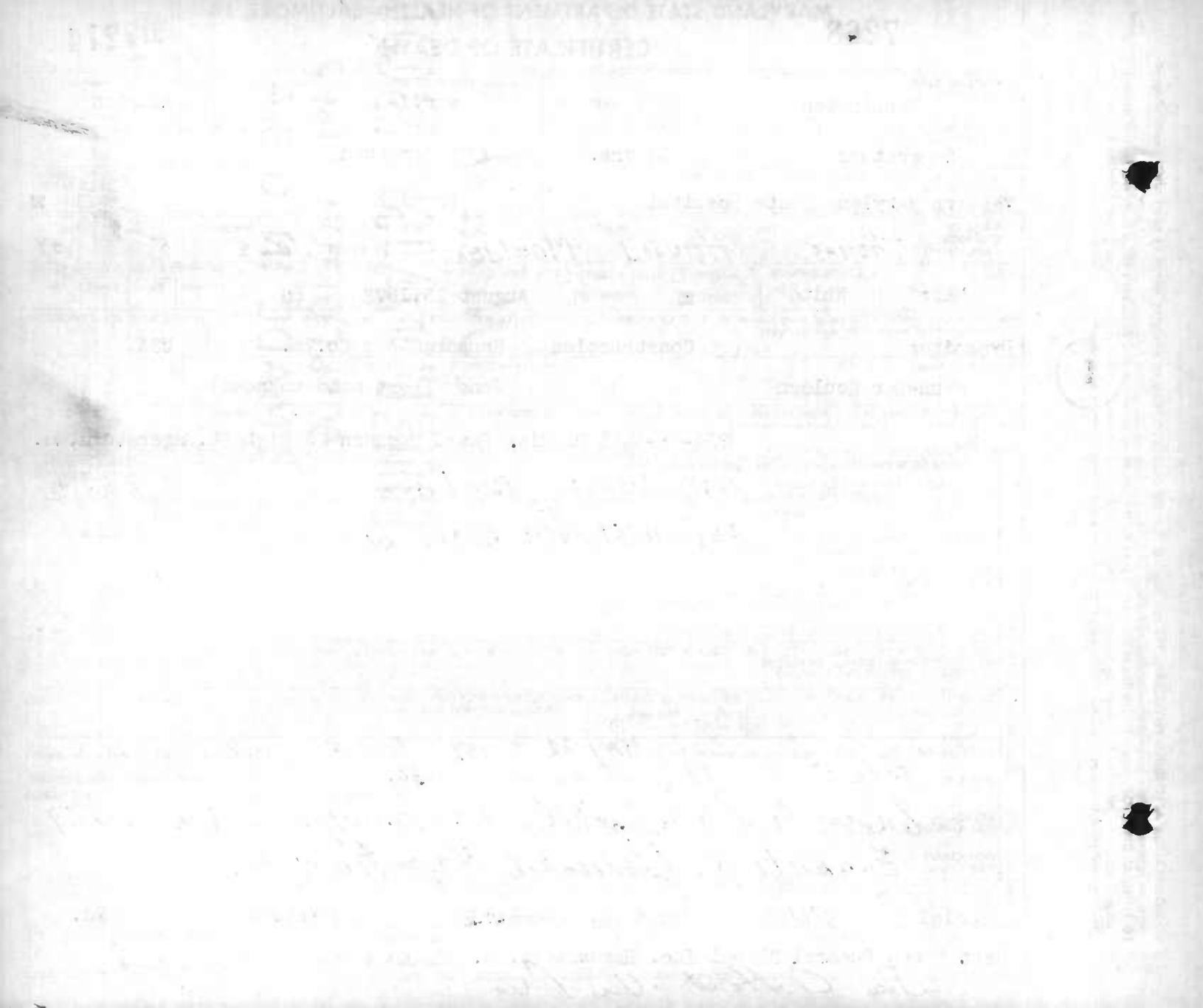
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07274

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS 23 High St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Howard Moulden		4. DATE OF DEATH JUNE 5 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dynamiter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Rappahannock Co. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mauncher Moulden		14. MOTHER'S MAIDEN NAME Jane (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-4881	
17. INFORMANT Miss Hazel Moulden		Address 23 High St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 1 YEAR		INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 22 , 19 59 , to JUNE 5 , 19 59 , that I last saw the deceased alive on JUNE 5 , 19 59 , and that death occurred at 1230 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Lardizabal M.D.		ADDRESS (Street, city or town, state) 1500 Pennsylvania AVE	
DATE SIGNED 6-5-59			
PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/8/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR JUN 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7310

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07275

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c. LENGTH OF STAY IN 1b 82 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 135 W. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle L Last Mumma		4. DATE OF DEATH Month June Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1877
9. AGE (In years at birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.A. Gov.	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Samuel Mumma		14. MOTHER'S MAIDEN NAME Frances Reichard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Bertha Mumma		Address 135 W. Main St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio vascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 54 to June 25 19 59 that I last saw the deceased alive on June 24 19 59 and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED June 27, 1959			
ACTUAL SIGNATURE Walter H. Shealy M.D.		DATE SIGNED June 27, 1959	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		Sharpsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27-59	
22c. NAME OF CEMETERY OR CREMATORY Mumma Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
ADDRESS Williamport, Md.		24b. REGISTRAR'S SIGNATURE Orlwin S. Hines	

7310

CERTIFICATE OF ADOPTION

112870

Adopted

Adopted

23 Nov.

Adopted

132 W. Main Street

132 W. Main Street

Adopted

Adopted

83

132 W. Main Street

132 W. Main Street

Adopted

Adopted

Adopted

Adopted

132 W. Main Street

132 W. Main Street

Adopted

Adopted

Adopted

83

83

Adopted

Adopted

83

83

83

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7269

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07276

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Hrs		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro R # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital						d. STREET ADDRESS Manor Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Unnamed Baby Girl Nave						4. DATE OF DEATH Month Day Year June 10 1959 19					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10 1959		9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR Months Days Hours Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles LeRoy Nave						14. MOTHER'S MAIDEN NAME Isabelle Younkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Charles L. Nave Boonsboro Md R # 1							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None										INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)	
21. I certify that I attended the deceased from 6-10-59 , to 6-10-59 , that I last saw the deceased alive on 6-10-59 , and that death occurred at 4:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 King St. Hagerstown DATE SIGNED 6-10-59 ACTUAL SIGNATURE Samuel F. Waddill M.D. PHYSICIAN'S NAME (Type) Samuel F. Waddill, M. D., 115 King St. Hagerstown, Md 6-10-59											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

2081245XY5

CERTIFICATE OF DEATH

7262

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1. NAME OF DECEASED Charles H. Davis		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 10 1895	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 10 1915	
9. PLACE OF DEATH Baltimore, Md.		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH Jan 10 1930	
13. SIGNATURE OF DECEASED Charles H. Davis		14. SIGNATURE OF WITNESS John Davis		15. SIGNATURE OF PHYSICIAN John Davis		16. SIGNATURE OF CLERK John Davis	
17. SIGNATURE OF REGISTRAR John Davis		18. SIGNATURE OF NOTARY John Davis		19. SIGNATURE OF JUDGE John Davis		20. SIGNATURE OF CLERK John Davis	

7270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		d. STREET ADDRESS 213 High St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rama Middle Blanche Last Niemyer		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1884
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Sharpsburg Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Jacob Mose		14. MOTHER'S MAIDEN NAME Ada L. Ecton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-34-3844	
INFORMANT William V. Niemyer		Address Route 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary - uterus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH years. 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 20, 1959 to June 17, 1959 , that I last saw the deceased alive on June 13, 1959 , and that death occurred at 6 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Phillip J. Hirshman		ADDRESS (Street, city or town, state) 159 W. Washington St	
DATE SIGNED June 17, 1959			
PHYSICIAN'S NAME (Type) Phillip J. Hirshman		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-19-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0730

UNITED STATES DEPARTMENT OF JUSTICE

Washington

May 1941

Memorandum

Subject:

Re:

Enclosure

Very truly yours,

Special Agent in Charge

June 17

Minneapolis

Dear Sir:

Reference is made to your letter of May 16, 1941.

Enclosed for the Bureau are two copies of a letterhead memorandum.

Very truly yours,

Special Agent in Charge

1

Very truly yours,

Special Agent in Charge

Minneapolis

Enclosure

June 17

Minneapolis

Enclosure

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Shepherdstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg 85 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River Bridge-Shepherdstown		d. STREET ADDRESS 224 Boyd Street	
3. NAME OF DECEASED (Type or print) First James Middle Curtis Last Owens		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1948
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Student	
11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Clark Owens		14. MOTHER'S MAIDEN NAME Audrey Risban	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William Clark Owens		Address 224 Boyd St. Martinsburg, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in Potomac River	
20c. TIME OF INJURY Hour 6 p. m. Month, Day, Year June 30 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Rural-Shepherdstown-Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-1-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1959	
22c. NAME OF CEMETERY OR CREMATORY Falling Waters Presbyterian		22d. LOCATION (City, town, or county) (State) Berkeley Co., W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown		ADDRESS Martinsburg, W. Va.	
24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH STATE OF NEW YORK	
DECEASED NAME: William Clark O'Connell SEX: Male RACE: White DATE OF BIRTH: Nov. 2, 1903 PLACE OF BIRTH: Brooklyn, N. Y. OCCUPATION: None RESIDENCE: Brooklyn, N. Y. DECEASED AT: Brooklyn, N. Y. DATE OF DEATH: Nov. 2, 1903 TIME OF DEATH: 10:30 P. M. CAUSE OF DEATH: Heart Disease MANNER OF DEATH: Natural SIGNATURE OF EXAMINER: W. H. O'Connell OFFICE OF THE MEDICAL EXAMINER: Brooklyn, N. Y. COUNTY: Kings CITY: Brooklyn STATE: New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown	
c. LENGTH OF STAY IN TB 1 Day		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Hospital		d. STREET ADDRESS Sharpsburg #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle SYLVESTER Last PATTERSON		4. DATE OF DEATH Month JUNE Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/1890
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Thurmont Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Patterson		14. MOTHER'S MAIDEN NAME Margaret Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes War 1		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Joseph Misner, Waynesboro Pa., #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE 527.1 DUE TO PULMONARY EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL SPASTIC INFANTILE PARALYSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 26 , 19 59 , to JUNE 27 , 19 59 , that I last saw the deceased alive on JUNE 26 , 19 59 , and that death occurred at 6:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Landigabal M.D.		ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave DATE SIGNED 6-27-59	
PHYSICIAN'S NAME (Type) Evaristo R. Landigabal		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/59	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa		24a. REC'D BY REGISTRAR JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

Howard Sylvester Patterson June 21 1912

STATE OF DEATH

June 20 1912

George R. Patterson
Patterson, Ind
June 20 1912

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07280

7271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 13 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 347 W. 2nd. St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN EDWARD PEIFFER JR.		4. DATE OF DEATH Month Day Year June 25, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hutcher Business		10b. KIND OF BUSINESS OR INDUSTRY Grindstone Hill	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Peiffer		14. MOTHER'S MAIDEN NAME Fianna Wingert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT John E. Peiffer Jr., 347 W. 2nd. St., Waynesboro Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia. Pulmonary infarction			INTERVAL BETWEEN ONSET AND DEATH 8 years-
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/12, 1959, to 6/25, 1959, that I last saw the deceased alive on 6/25, 1959, and that death occurred at 9:30AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Horenbaker M.D. 154 W. WASHINGTON ST. 6/26/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) JOHN H. HORENBAKER, M.D. HAGERSTOWN, MD -			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/59	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE JUN 30 '59 24b. REGISTRAR'S SIGNATURE Arthur E. K...	

CERTIFICATE OF DEATH

1917

File No.

County

Age

Sex

Color

Place of Birth

City or Town

State

Occupation

Married

Signature

Witness

Physician

Signature

Witness

Physician

Signature

Witness

Physician

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7313

CERTIFICATE OF DEATH

Reg. Dist. No.

07281

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Antietam Station				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle Mc Kinley Last Petefish				4. DATE OF DEATH Month June Day 27 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22 1906	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 5 Days 4	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Stanley Va		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Vernon Lee Petefish				14. MOTHER'S MAIDEN NAME Minnie Aleshire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 719 07 6489		INFORMANT Mrs. Mabel Petefish near Antietam Station Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Chronic 15 MIN						INTERVAL BETWEEN ONSET AND DEATH 15 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-27-59 to 6-27-59 that I last saw the deceased alive on 6-27-59 , 19 59 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Shepherd M.D.				ADDRESS (Street, city or town, state) Shepherdstown WVA DATE SIGNED 6-27-59			
PHYSICIAN'S NAME (Type) William Shepherd							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30-59		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kiser				ADDRESS 2111 W. Williamsport, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	
				24a. REC'D BY REGISTRAR DATE JUN 30 '59			

1951

OFFICE OF THE

MEMORANDUM FOR THE DIRECTOR, FBI
SUBJECT: [Illegible]

TO: [Illegible]
FROM: [Illegible]
DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7314

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE - RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE - RURAL</u>		d. STREET ADDRESS <u>1 ROHRERSVILLE MD. D.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROHRERSVILLE MD. D.O.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALVEY</u> Middle <u>CLARENCE</u> Last <u>POFFENBERGER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 22 - 1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED OPERATOR OF COUNTRY STORE</u>		11. BIRTHPLACE (State or foreign country) <u>LOCUST GROVE WASH. Co. MD. U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>LAWRENCE POFFENBERGER</u>			
14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>218-30-9152</u>				17. INFORMANT <u>MRS. RUTH POFFENBERGER ROHRERSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>58</u> , to <u>June 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>59</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. H. Van</u>				ADDRESS (Street, city or town, state) <u>Boonsboro</u>			
PHYSICIAN'S NAME (Type) <u>G. W. H. Van</u>				DATE SIGNED <u>6/18/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE-20-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				ADDRESS <u>Boonsboro MD.</u>		24a. REC'D BY REGISTRAR <u>JUN 23 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

7272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07283

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 408 W. Washington Street				d. STREET ADDRESS 408 W. Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK CLINTON PRICE				4. DATE OF DEATH Month Day Year June 7 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Pipe supply Co.		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease DUE TO with myocardial failure grade iv; Conditions, if any, which gave rise to immediate cause (b) Emphysema (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-9-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/10/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR June 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

2

1978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

302

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]

DECEASED AT: [illegible]
CITY: [illegible]
STATE: [illegible]

DATE OF DEATH: [illegible]
TIME OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

DEATH CERTIFICATE NO. [illegible]
ISSUED BY: [illegible]

DATE OF EXAMINATION: [illegible]
EXAMINER'S SIGNATURE: [illegible]

DEATH CERTIFICATE NO. [illegible]
ISSUED BY: [illegible]

DATE OF EXAMINATION: [illegible]
EXAMINER'S SIGNATURE: [illegible]

DEATH CERTIFICATE NO. [illegible]
ISSUED BY: [illegible]

DATE OF EXAMINATION: [illegible]
EXAMINER'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
Item 18 Film 243 6-11-59 ams													
CERTIFICATE OF DEATH													
Reg. Dist. No. 07284													
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 45 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 126 W. Baltimore St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) CATHERINE ELIZABETH RICKARD				4. DATE OF DEATH JUNE 5 1959									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1882		9. AGE (In years birth day) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Martin V. Green						14. MOTHER'S MAIDEN NAME Susan Smith							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-26-8480		INFORMANT Clayton Rickard Hagerstown Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE OVARY WITH METASTASES DUE TO Carcinoma of ovary with generalized metastases (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIO-VASCULAR DISEASE, BRADYCARDIA										INTERVAL BETWEEN ONSET AND DEATH 5 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from APRIL 22 , 19 59 , to JUNE 5 , 19 59 , that I last saw the deceased alive on JUNE 5 , 19 59 , and that death occurred at 8:20 AM , from the causes and on the date stated above.													
ACTUAL SIGNATURE Evaristo R. Lardizabal				ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE				DATE SIGNED 6-5-59					
PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal				Hagerstown, Md.									
22a. BURIAL, CREMATION, or other (Specify) Burial				22b. DATE THEREOF 6-8-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son						ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1973

Washington

Maryland

Washington

Hagerstown

45 years

Hagerstown

20 W. Baltimore St.

Western Maryland State Hospital

Feb. 11, 1982

White

Maryland

Own Home

Home

Green

Green

115-22-8430-1212 Hagerstown, Md.

7274

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film 6244 7-20-59 et
CERTIFICATE OF DEATH

07285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b one hour			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport RFD #2			
f. STREET ADDRESS 16 Reynolds Road Mt. Tammany				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lee Roy Rider				4. DATE OF DEATH Month Day Year June 10 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16 1907	
9. AGE (In years last birthday) 52 51 yrs.		10. IF UNDER 1 YEAR Months Days 6 21		11. IF UNDER 24 HRS. Hours Min. 6 21			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Label Mill		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Grant Rider				14. MOTHER'S MAIDEN NAME Effie Boward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 07 4258		17. INFORMANT Mrs. Catherine Rider			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1 Day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/10/59 , 19____, to 6/10/59 , 19____, that I last saw the deceased alive on 6/10/59 , 19____, and that death occurred at Williamsport Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Albert L. Wolf Williamsport Md. 6/11/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12-59		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf Williamsport Md.				24a. REC'D BY REGISTRAR DATE JUN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7275

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 62 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Emory & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 251 West Side Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ada Pearl Ringer		4. DATE OF DEATH Month June Day 24, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Simon Baker		14. MOTHER'S MAIDEN NAME Laura Ambrose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Address Charles K. Ringer, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. E. W. Dittor Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) J. E. W. Dittor Jr		DATE SIGNED 6/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6-27-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. REGISTRAR'S SIGNATURE 	

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

EDWARD
68 years

222 and 2100 Ave.

and

and

1887

born home

Simon

Inspector, Sheriff, Registrar

6-2-22

1922

1922

Inspector, Sheriff, Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7276

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07287

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 E. ANTIETAM ST.		d. STREET ADDRESS 101 E. ANTIETAM ST.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTHA ALICE ROHRER		4. DATE OF DEATH Month JUNE Day 1 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1879
9. AGE (In years lost birthday) 80		10. IF UNDER 1 YEAR: Months 80 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY HOME	
13. FATHER'S NAME JOHN H. YOUNG		14. MOTHER'S MAIDEN NAME HENRIETTA COFFMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. J. HOWARD ROHRER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 Day DUE TO (c) 1 Day		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/3/59 , 19____, to 6/1/59 , 19____, that I last saw the deceased alive on 6/1/59 , 19____, and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Young M.D.		DATE SIGNED 6/3/59	
PHYSICIAN'S NAME (Type) RALPH F. YOUNG			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/4/59	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

7277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

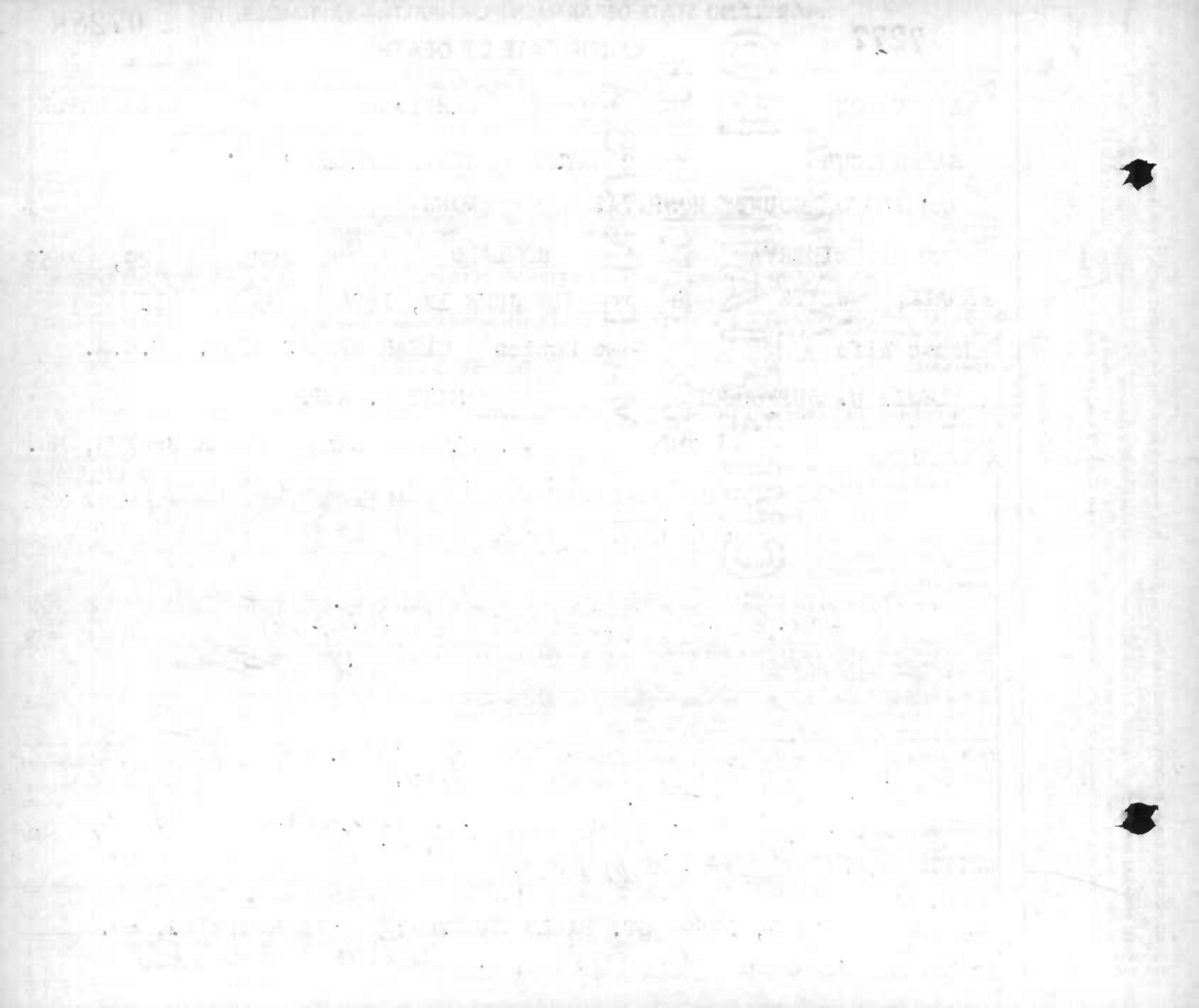
07288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINERVA Middle ROWLAND Last				4. DATE OF DEATH Month JUNE Day 29 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12, 1874	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months 13 Days 19 Hours 59 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home Duties			
11. BIRTHPLACE (State or foreign country) CLEAR SPRING DIST.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEWIS W. SUFFECOO				14. MOTHER'S MAIDEN NAME MARY E. REPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
INFORMANT LAWRENCE ROWLAND				Address CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis (General) DUE TO (c) 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis. Emphysema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 25, 1959 , to June 29, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 1200 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED June 30, 1959							
ACTUAL SIGNATURE J. H. Beachley M.D.							
PHYSICIAN'S NAME (Type) J. H. Beachley							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 2, 1959		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark Clear Spring, Md				24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7278

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> 10 X - 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>RONALD</u> Middle <u>E</u> Last <u>RUDY</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>type setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>newspaper office Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Vera C. Rudy</u>		14. MOTHER'S MAIDEN NAME <u>Ida Clem</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-9805</u>	
17. INFORMANT <u>Willard Rudy, Frederick, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GASTRO-INTestinal ULCER</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John D. Turg</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John D. Turg</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-27-59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/30/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Prana</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

1918

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. MANNER OF DEATH</p> <p>14. SIGNATURE OF EXAMINER</p> <p>15. DATE OF EXAMINATION</p> <p>16. PLACE OF EXAMINATION</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. DATE OF DEATH</p> <p>19. PLACE OF DEATH</p> <p>20. SIGNATURE OF CORONER</p> <p>21. DATE OF CORONER'S EXAMINATION</p> <p>22. PLACE OF CORONER'S EXAMINATION</p> <p>23. SIGNATURE OF JURY</p> <p>24. DATE OF JURY'S EXAMINATION</p> <p>25. PLACE OF JURY'S EXAMINATION</p> <p>26. SIGNATURE OF JUDGE</p> <p>27. DATE OF JUDGE'S EXAMINATION</p> <p>28. PLACE OF JUDGE'S EXAMINATION</p> <p>29. SIGNATURE OF CLERK</p> <p>30. DATE OF CLERK'S EXAMINATION</p> <p>31. PLACE OF CLERK'S EXAMINATION</p> <p>32. SIGNATURE OF SHERIFF</p> <p>33. DATE OF SHERIFF'S EXAMINATION</p> <p>34. PLACE OF SHERIFF'S EXAMINATION</p> <p>35. SIGNATURE OF CONSTABLE</p> <p>36. DATE OF CONSTABLE'S EXAMINATION</p> <p>37. PLACE OF CONSTABLE'S EXAMINATION</p> <p>38. SIGNATURE OF TOWNSHIP CLERK</p> <p>39. DATE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>40. PLACE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>41. SIGNATURE OF COUNTY CLERK</p> <p>42. DATE OF COUNTY CLERK'S EXAMINATION</p> <p>43. PLACE OF COUNTY CLERK'S EXAMINATION</p> <p>44. SIGNATURE OF STATE CLERK</p> <p>45. DATE OF STATE CLERK'S EXAMINATION</p> <p>46. PLACE OF STATE CLERK'S EXAMINATION</p> <p>47. SIGNATURE OF ATTORNEY GENERAL</p> <p>48. DATE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>49. PLACE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>50. SIGNATURE OF COMPTROLLER</p> <p>51. DATE OF COMPTROLLER'S EXAMINATION</p> <p>52. PLACE OF COMPTROLLER'S EXAMINATION</p> <p>53. SIGNATURE OF TREASURER</p> <p>54. DATE OF TREASURER'S EXAMINATION</p> <p>55. PLACE OF TREASURER'S EXAMINATION</p> <p>56. SIGNATURE OF SHERIFF</p> <p>57. DATE OF SHERIFF'S EXAMINATION</p> <p>58. PLACE OF SHERIFF'S EXAMINATION</p> <p>59. SIGNATURE OF CONSTABLE</p> <p>60. DATE OF CONSTABLE'S EXAMINATION</p> <p>61. PLACE OF CONSTABLE'S EXAMINATION</p> <p>62. SIGNATURE OF TOWNSHIP CLERK</p> <p>63. DATE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>64. PLACE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>65. SIGNATURE OF COUNTY CLERK</p> <p>66. DATE OF COUNTY CLERK'S EXAMINATION</p> <p>67. PLACE OF COUNTY CLERK'S EXAMINATION</p> <p>68. SIGNATURE OF STATE CLERK</p> <p>69. DATE OF STATE CLERK'S EXAMINATION</p> <p>70. PLACE OF STATE CLERK'S EXAMINATION</p> <p>71. SIGNATURE OF ATTORNEY GENERAL</p> <p>72. DATE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>73. PLACE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>74. SIGNATURE OF COMPTROLLER</p> <p>75. DATE OF COMPTROLLER'S EXAMINATION</p> <p>76. PLACE OF COMPTROLLER'S EXAMINATION</p> <p>77. SIGNATURE OF TREASURER</p> <p>78. DATE OF TREASURER'S EXAMINATION</p> <p>79. PLACE OF TREASURER'S EXAMINATION</p> <p>80. SIGNATURE OF SHERIFF</p> <p>81. DATE OF SHERIFF'S EXAMINATION</p> <p>82. PLACE OF SHERIFF'S EXAMINATION</p> <p>83. SIGNATURE OF CONSTABLE</p> <p>84. DATE OF CONSTABLE'S EXAMINATION</p> <p>85. PLACE OF CONSTABLE'S EXAMINATION</p> <p>86. SIGNATURE OF TOWNSHIP CLERK</p> <p>87. DATE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>88. PLACE OF TOWNSHIP CLERK'S EXAMINATION</p> <p>89. SIGNATURE OF COUNTY CLERK</p> <p>90. DATE OF COUNTY CLERK'S EXAMINATION</p> <p>91. PLACE OF COUNTY CLERK'S EXAMINATION</p> <p>92. SIGNATURE OF STATE CLERK</p> <p>93. DATE OF STATE CLERK'S EXAMINATION</p> <p>94. PLACE OF STATE CLERK'S EXAMINATION</p> <p>95. SIGNATURE OF ATTORNEY GENERAL</p> <p>96. DATE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>97. PLACE OF ATTORNEY GENERAL'S EXAMINATION</p> <p>98. SIGNATURE OF COMPTROLLER</p> <p>99. DATE OF COMPTROLLER'S EXAMINATION</p> <p>100. PLACE OF COMPTROLLER'S EXAMINATION</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7279

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 4, 22 Film G243 6-15-59 et
CERTIFICATE OF DEATH

07290

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 wk d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 5 d. STREET ADDRESS Ringgold e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last LENA RUSH SACHS		4. DATE OF DEATH 6-8-59 Month Day Year June 8 1959 19				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 11 1879	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Berne Switzerland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Rush			14. MOTHER'S MAIDEN NAME Anna Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Mary Zello Hagerstown Md R # 5		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-4-59 , 19____, to 6-8-59 , 19____, that I last saw the deceased alive on 6-7-59 , 19____, and that death occurred at 3:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 6-8-59 ACTUAL SIGNATURE Charles F. Hess M.D. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/59		22c. NAME OF CEMETERY OR CREMATORY Adolph Cemetery		22d. LOCATION (City, town, or county) (State) Adolph Randolph Co W Va.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus

7280

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07291

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL CLEAR SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle SERIG Last SERIG		4. DATE OF DEATH Month 6 Day 29 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1883
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES A. STENTZEL		14. MOTHER'S MAIDEN NAME GUSSIE GROSQUE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLES SERIG		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1957 to June 29, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 10:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 W. Washington St. DATE SIGNED 6-30-59			
ACTUAL SIGNATURE L. L. Packer, Jr. M.D.		DATE SIGNED 6-30-59	
PHYSICIAN'S NAME (Type) L. L. Packer, Jr., M.D.		Address Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/2/1959	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clear Spring, Md.	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R. 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SHARAN KAY SHANHOLTZ</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 2 - 19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE - 1 - 1959</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KENNETH SHANHOLTZ</u>				14. MOTHER'S MAIDEN NAME <u>DIANA MINNICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>KENNETH SHANHOLTZ HAGERSTOWN MD. R. 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hypertensive Membrane</u> <u>773.5</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>59</u> , to <u>6/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Young</u> M.D.				ADDRESS (Street, city or town, state) <u>101 King Street Hagerstown, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Griffin S. Howard</u>	

1921

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

By the

Name of deceased		Age		Sex		Race		Color		Religion		Marital status		Occupation		Cause of death		Place of death		Date of death		Time of death		Signature of physician		Signature of registrar		Signature of witness	
John Doe		45		Male		White		White		Roman Catholic		Married		Farmer		Heart disease		Home		Jan 15, 1921		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of birth		Date of birth		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure	
New York		Jan 1, 1876		Jan 15, 1921		Jan 18, 1921		Jan 20, 1921		Jan 22, 1921		Jan 24, 1921		Jan 26, 1921		Jan 28, 1921		Jan 30, 1921		Feb 1, 1921		Feb 3, 1921		Feb 5, 1921		Feb 7, 1921		Feb 9, 1921	
Place of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Home		Jan 15, 1921		Jan 18, 1921		Jan 20, 1921		Jan 22, 1921		Jan 24, 1921		Jan 26, 1921		Jan 28, 1921		Jan 30, 1921		Feb 1, 1921		Feb 3, 1921		Feb 5, 1921		Feb 7, 1921		Feb 9, 1921		Feb 11, 1921	
Cause of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Heart disease		Jan 15, 1921		Jan 18, 1921		Jan 20, 1921		Jan 22, 1921		Jan 24, 1921		Jan 26, 1921		Jan 28, 1921		Jan 30, 1921		Feb 1, 1921		Feb 3, 1921		Feb 5, 1921		Feb 7, 1921		Feb 9, 1921		Feb 11, 1921	
Place of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Home		Jan 15, 1921		Jan 18, 1921		Jan 20, 1921		Jan 22, 1921		Jan 24, 1921		Jan 26, 1921		Jan 28, 1921		Jan 30, 1921		Feb 1, 1921		Feb 3, 1921		Feb 5, 1921		Feb 7, 1921		Feb 9, 1921		Feb 11, 1921	
Cause of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Heart disease		Jan 15, 1921		Jan 18, 1921		Jan 20, 1921		Jan 22, 1921		Jan 24, 1921		Jan 26, 1921		Jan 28, 1921		Jan 30, 1921		Feb 1, 1921		Feb 3, 1921		Feb 5, 1921		Feb 7, 1921		Feb 9, 1921		Feb 11, 1921	

3

1

RECEIVED
JAN 16 1921
STATE DEPARTMENT OF HEALTH
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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7282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>112 West Franklin St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>JEAN</u> Last <u>SHANK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1959</u>
9. AGE (In years lost birthday) yrs. <u>35</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin Shank Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Ellen House</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary House</u>		Address <u>112 W. Franklin St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1</u> , 19 <u>59</u> , to <u>JUNE 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel F. Waddell</u> M.D.		ADDRESS (Street, city or town, state) <u>115 King St. Hagerstown</u>	
DATE SIGNED <u>6-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Samuel F. Waddell</u>		ADDRESS <u>115 King St. Hagerstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

2081161XVI

7283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		c. LENGTH OF STAY IN 1b 5yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 450 Park Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Wallace Shedd				4. DATE OF DEATH Month Day Year June 27 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 12 1933		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Gowan, Tennessee		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Shedd				14. MOTHER'S MAIDEN NAME Hassie Marbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War-2 408-48-5458		17. INFORMANT Address Phyllis Shedd 450 Park Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 919.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound of neck penetrating lungs (c) Cuts on large vessels of neck							INTERVAL BETWEEN ONSET AND DEATH 20 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot by rifle					
20c. TIME OF INJURY Month, Day, Year Hour 6-27-59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Handy Wash Mfg		20f. (City or town) (County) (State) Washington Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. SW. Little				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) IT E W Little Jr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

383

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White	
DATE OF DEATH 10-15-1918		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		MEDICAL HISTORY None	
SIGNATURE OF EXAMINER J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF PHYSICIAN J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF FUNERAL HOME J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF BURIAL PLACE J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF NEXT OF KIN J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF SECOND WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF THIRD WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF FOURTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF FIFTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF SIXTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF SEVENTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF EIGHTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF NINTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	
NAME OF TENTH WITNESS J. H. Harris		DATE 10-15-1918		PLACE Baltimore		COUNTY Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07295

7315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b X FUNKSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME				d. STREET ADDRESS 1 STOFFER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD H. SHIELER				4. DATE OF DEATH Month Day Year JUNE - 29, 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 21, 1869	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 6 8		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) LOCUST GROVE WASH. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE SHIELER				14. MOTHER'S MAIDEN NAME ELIZABETH HUEFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT DAVID E. SHIELER FUNKSTOWN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalize arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 15, 1959 , to June 29, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 2:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. LeVan				ADDRESS (Street, city or town, state) Boonsboro		DATE SIGNED 6/30/59	
PHYSICIAN'S NAME (Type) G. W. LeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 2, 1959		22c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bass				ADDRESS Boonsboro MD		24a. REC'D BY REGISTRAR DATE JUL 8 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1918

NAME OF DECEASED _____

AGE _____

SEX _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

DATE OF INTERMENT _____

PLACE OF INTERMENT _____

SIGNATURE OF PHYSICIAN _____

SIGNATURE OF MINISTER OF THE GOSPEL _____

SIGNATURE OF CORONER _____

SIGNATURE OF DEPUTY CLERK _____

SIGNATURE OF CLERK _____

SIGNATURE OF JUDGE _____

SIGNATURE OF SHERIFF _____

SIGNATURE OF TOWNSHIP CLERK _____

SIGNATURE OF COUNTY CLERK _____

SIGNATURE OF STATE CLERK _____

SIGNATURE OF U.S. MARSHAL _____

SIGNATURE OF U.S. ATTORNEY _____

SIGNATURE OF U.S. SENATOR _____

7284

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 Mo			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge 10X-2				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Chronic Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clayton Emanuel Shriner First Middle Last				4. DATE OF DEATH JUNE 30 Month Day Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 29. 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY on Farms		11. BIRTHPLACE (State or foreign country) Frederick		12. CITIZEN OF WHAT COUNTRY? U.s.A	
13. FATHER'S NAME Joseph Shriner				14. MOTHER'S MAIDEN NAME Laura Eyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		INFORMANT Mrs Elsie Wastler		Address Thurmont. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) CEREBROVASCULAR ACCIDENT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 6 , 19 58 , to JUNE 30 , 19 59 , that I last saw the deceased alive on JUNE 30 , 19 59 , and that death occurred at 4:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eugene R. Laddizol		ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave NW 6-30-59 DATE SIGNED					
PHYSICIAN'S NAME (Type) Eugene R. Laddizol		Hagerstown Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3. 1958		22c. NAME OF CEMETERY OR CREMATORY Mt Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge MD	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager ADDRESS Thurmont Md				24a. REC'D BY REGISTRAR JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

1934

Washington

Washington

Western R.R. Chicago New York

White 29.1935 73

on forms

Joseph Smith

James E. Smith

Miss Alice Washburn

no

Thurmont.

Washington

Washington

29.1.1935 73

Thurmont

Thurmont

FOR STATE
HEALTH DEPT.

TO DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

1
7285 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07297
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Washington County Hospital		4. STREET ADDRESS Route 3	
3. NAME OF DECEASED (Type or print) First Lewis Middle Thomas Last Shutters		4. DATE OF DEATH Month June Day 9 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Repair	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Shutters		14. MOTHER'S MAIDEN NAME Nannie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 043-07-8655	
17. INFORMANT Address Mrs Sylvia Shutters Route 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture abdominal aneurysm (aortic) 451x DUE TO Vascular hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 6-12-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-12-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

2

RP2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: J. H. Hinton

RESIDENCE: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

CAUSE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

PLACE OF DEATH: J. H. Hinton

DATE OF DEATH: J. H. Hinton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7286

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD</u> <u>SNYDER</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>2</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5 - 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED KEEPER OF CEMETERY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KEEDYSVILLE WASH. Co MD. U.S.A</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HIRAM SNYDER</u>		14. MOTHER'S MAIDEN NAME <u>LUCINDA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MINNIE SNYDER</u>		Address <u>KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>610X</u> DUE TO <u>Bilateral hydropnephrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophy of prostate</u> DUE TO (c) <u>Hypertrophy of prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>6-2-1959</u> , that I last saw the deceased alive on <u>6-1-</u> , 19 <u>59</u> , and that death occurred at <u>5:25</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro MD.</u> DATE SIGNED <u>Boonsboro MD.</u>			
ACTUAL SIGNATURE <u>Joseph Secondary</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 5 - 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor discoloration and faint, illegible markings. Two prominent, dark, irregular ink blotches are visible: one near the top center and another near the bottom center. The page is otherwise empty of text or illustrations.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

VS. A15ME(5)
SM 9/55

7287

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6244 6-23-59 et

09620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD. c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS CUMBERLAND ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISEY Middle CATHERINE Last STALEY		4. DATE OF DEATH Month JUNE Day 15 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28 1900
9. AGE (In years last birthday) 58 59 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties	
11. KIND OF BUSINESS OR INDUSTRY House Work		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MILLS		14. MOTHER'S MAIDEN NAME BARBARA ELLEN MCCARTHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLES STALEY		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fracture ribs (closed) DUE TO Fractured rt. humerus (closed) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary artery thrombosis - acute DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 113 hrs 113 hrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto that struck a tree when forced off road	
20c. TIME OF INJURY Hour 6:20 p. m. Month, Day, Year June 10 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural Clearspring Wash, Md (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 6-16-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEM.		22d. LOCATION (City, town, or county) ST. PAUL, MD. NR. CLSPG, MD. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Clark ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR JUN 18 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. OCCUPATION [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. DATE OF BIRTH [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JURY [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
39. SIGNATURE OF JURY [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]	
45. SIGNATURE OF JURY [REDACTED]		46. SIGNATURE OF JURY [REDACTED]	
47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
51. SIGNATURE OF JURY [REDACTED]		52. SIGNATURE OF JURY [REDACTED]	
53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]	
57. SIGNATURE OF JURY [REDACTED]		58. SIGNATURE OF JURY [REDACTED]	
59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
63. SIGNATURE OF JURY [REDACTED]		64. SIGNATURE OF JURY [REDACTED]	
65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
69. SIGNATURE OF JURY [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]	
75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]	
87. SIGNATURE OF JURY [REDACTED]		88. SIGNATURE OF JURY [REDACTED]	
89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]	
93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

7288

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Washington County Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75 x - 3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 206 Wayne Avenue			
3. NAME OF DECEASED (Type or print) First Marvin Middle Elwood Last Stewart				4. DATE OF DEATH Month June Day 13 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1917	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME David H. Stewart			
14. MOTHER'S MAIDEN NAME Ida M. Hill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) # 2			
16. SOCIAL SECURITY NO. 188-09-5085				17. INFORMANT Address Mrs. Catherine Stewart- 206 Wayne Ave Waynesboro, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO Hemothorax; shock; Concussion Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that failed to negotiate a curve and hit a tree			
20c. TIME OF INJURY Hour 12:30 AM Month, Day, Year June 12, 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-59		22c. NAME OF CEMETERY OR CREMATORY Harbaugh's Cemetery		22d. LOCATION (City, town, or county) (State) Wash. Township-Franklin Co, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Groves				ADDRESS Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1938
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

NAME OF DECEASED Miss. [illegible]		SEX Female	
DATE OF BIRTH [illegible]		PLACE OF BIRTH [illegible]	
DATE OF DEATH [illegible]		PLACE OF DEATH [illegible]	
TIME OF DEATH [illegible]		CAUSE OF DEATH [illegible]	
MANNER OF DEATH [illegible]		MEDICAL EXAMINER'S SIGNATURE [illegible]	
COUNTY [illegible]		CITY [illegible]	
STATE Maryland		ZIP CODE [illegible]	
DECEASED'S RESIDENCE [illegible]		DECEASED'S OCCUPATION [illegible]	
DECEASED'S MARITAL STATUS [illegible]		DECEASED'S EDUCATION [illegible]	
DECEASED'S RELIGION [illegible]		DECEASED'S RACE [illegible]	
DECEASED'S COLOR [illegible]		DECEASED'S HEIGHT [illegible]	
DECEASED'S WEIGHT [illegible]		DECEASED'S BUILD [illegible]	
DECEASED'S HAIR [illegible]		DECEASED'S EYES [illegible]	
DECEASED'S SKIN [illegible]		DECEASED'S TEETH [illegible]	
DECEASED'S FINGERS [illegible]		DECEASED'S TOES [illegible]	
DECEASED'S NAILS [illegible]		DECEASED'S SCARS [illegible]	
DECEASED'S TATTOOS [illegible]		DECEASED'S OTHER MARKS [illegible]	
DECEASED'S DISEASES [illegible]		DECEASED'S SURGICAL HISTORY [illegible]	
DECEASED'S PRESENT ILLNESS [illegible]		DECEASED'S PRESENT TREATMENT [illegible]	
DECEASED'S PRESENT LOCATION [illegible]		DECEASED'S PRESENT ATTENDING PHYSICIAN [illegible]	
DECEASED'S PRESENT ADDRESS [illegible]		DECEASED'S PRESENT PHONE [illegible]	
DECEASED'S PRESENT MAILING ADDRESS [illegible]		DECEASED'S PRESENT MAILING PHONE [illegible]	
DECEASED'S PRESENT MAILING CITY [illegible]		DECEASED'S PRESENT MAILING STATE [illegible]	
DECEASED'S PRESENT MAILING ZIP CODE [illegible]		DECEASED'S PRESENT MAILING COUNTRY [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md.		c. LENGTH OF STAY IN 1b 60 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 70 W. Main St.	
3. NAME OF DECEASED (Type or print) First Homer Middle Edwin Last Tabler		4. DATE OF DEATH Month 6 Day 9 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4.25.1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 1 Days 15	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr of Medicine		10b. KIND OF BUSINESS OR INDUSTRY Dr of Medicine	
11. BIRTHPLACE (State or foreign country) Bedington W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E.S. Tabler		14. MOTHER'S MAIDEN NAME Katherine Whitmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Laura C Tabler		Address 70 W. Main St. Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 min. 2 yrs 20 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1959 , to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at 10:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank B Thomas III M.D.		ADDRESS (Street, city or town, state) 121 High Street	
DATE SIGNED 6-12-59			
PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D. Hancock, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.12.59	
22c. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Skore Hancock Md		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7317

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 81 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 E. Potomac Street				e. STREET ADDRESS 27 E. Potomac Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Jackson Last Taylor				4. DATE OF DEATH Month June Day 11 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17 1867	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 7 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Owner		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Jackson Taylor				14. MOTHER'S MAIDEN NAME Christie Ann Newcomer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Robert Taylor Williamsport Md RFD 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 1 Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10/59 19 to 6/11/59 19, that I last saw the deceased alive on 6/10/59 19, and that death occurred at 9:00 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport Md DATE SIGNED 6/11/59							
ACTUAL SIGNATURE Ralph F Young M.D.		PHYSICIAN'S NAME (Type) William Young					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13-59		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Leaf Williamsport, Md				24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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7288

CERTIFICATE OF DEATH

07302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bakersville Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Bakersville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Vickers Last Vickers		4. DATE OF DEATH Month June Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16 1879
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bowers		14. MOTHER'S MAIDEN NAME Mary Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Enoch E. Vickers		Address Bakersville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & chronic cholecystitis & shock 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetics - Cardiomegaly - DUE TO (c) Diabetics - Cardiomegaly - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetics - Cardiomegaly - INTERVAL BETWEEN ONSET AND DEATH 2 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year June 17, 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1958 to June 17, 1959 that I last saw the deceased alive on June 17, 1959 , and that death occurred at 1:38 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Byrkit		ADDRESS (Street, city or town, state) 28 W. Potomac	
PHYSICIAN'S NAME (Type) M. E. Byrkit		DATE SIGNED 6-18-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 20-59	
22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

41302

STATE OF TEXAS

1938

County of ...
State of Texas
Know all men by these presents, that ...
do hereby certify that ...
is the true and correct copy of the ...
as the same appears from the records of the ...
County of ... State of Texas.

1

Witness my hand and the seal of the County of ...
this ... day of ... 1938.
County Clerk

7318

CERTIFICATE OF DEATH

07303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shippensburg, Pa</u>	
c. LENGTH OF STAY IN <u>2 yrs.</u>		d. STREET ADDRESS <u>365 E. King St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>B</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR <u>5</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Co, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Flavie B. Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mains</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Beattie Watson, 365 E King St.</u>		Address <u>Shippensburg, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Mononucleosis + Debility</u> 1343 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General debility + Systemic infection</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1, 19 58</u> to <u>June 29, 19 59</u> , that I last saw the deceased alive on <u>June 28, 19 59</u> , and that death occurred at <u>3:40</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ME Byrkit</u> M.D.		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>6-29-59</u>	
PHYSICIAN'S NAME (Type) <u>ME Byrkit</u>		<u>Williamsport Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-1-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Shippensburg Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leaf</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Christina B. Pines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7290

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07304

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 820 Washington Ave				d. STREET ADDRESS 820 Washington Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE ELIZABETH WIDMYER				4. DATE OF DEATH Month Day Year June 10 1959 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Downsville Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Cline				14. MOTHER'S MAIDEN NAME Martha Detrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-2153		17. INFORMANT Address Miss Mary Ditlow 820 Washington Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO General Arterio Sclerosis (c) 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1959 to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at 10:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 6/12/59							
ACTUAL SIGNATURE J. N. Beachley		M.D. Arthur S. Knaus					
PHYSICIAN'S NAME (Type) J. N. Beachley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/59		22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

7291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film G244 6-22-59 et
 CERTIFICATE OF DEATH

07305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 20 min.		d. STREET ADDRESS -1 427 MdDowell Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle I Last Worthington		4. DATE OF DEATH Month 6 Day 15 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1885
9. AGE (In years lost birthday) 63 5/4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Carroll Co. Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew C. Morgan		14. MOTHER'S MAIDEN NAME Martha A. Rohrer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John Perrott		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerotic Heart Disease with 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular Fibrillation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity & Arteriosclerosis; Spontaneous Myocardial Infarction 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 59 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 2 years
21. I certify that I attended the deceased from 4-28-59 to 6-15-59 that I last saw the deceased alive on 6-15-59 , and that death occurred at 9:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 998 Potomac Ave Hagerstown, Maryland DATE SIGNED ACTUAL SIGNATURE DALTON M. WELTY M.D. PHYSICIAN'S NAME (Type) DALTON M. WELTY			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-18-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		24b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

